15 PRINCIPLES FOR REDUCING THE RISK OF RESTRAINT-RELATED DEATH

POLICE EXECUTIVE RESEARCH FORUM

September 2024

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MESSAGE FROM PERF EXECUTIVE DIRECTOR CHUCK WEXLER

In early 2024, the Associated Press (AP) published an investigative series entitled "Lethal Restraint," examining incidents in which people died while or after being restrained by police.[1] One grim takeaway of the AP's extensive investigation was that "over a decade, more than 1,000 people died after police subdued them through … means not intended to be lethal."[2] The series also recognized that many of these unintended deaths had resulted from inadequate law enforcement training.

Police want guidance about how best to avoid restraint-related deaths, but much of the public discourse on the subject has focused on the terminology that is used to describe these incidents.[3] PERF has previously observed that public debates about language "avoid[s] the harder issue of how police, EMS, and others can improve their response to medical-behavioral emergencies."[4] To address this gap, PERF organized a meeting on June 27, 2024, convening a diverse group of police, emergency medical technicians, physicians, and policy/tactical experts.[5] The meeting aimed to create guidance for police on how to handle situations that may necessitate restraint but could also pose a heightened risk to the individual being restrained. This document contains the recommendations formulated during that meeting.

Nearly all guidance in this report can be applied to any situation, and all reinforce PERF's long-held principle that the sanctity of life should govern police encounters, with the consistent goal of every person going home safely.[6] However, in this publication, we have focused on a common type of incident for which police seek guidance — how to safely handle cases involving people who are difficult to control and disproportionately die during or after police restraint [See PRINCIPLE 1]. As Sergeant John Flynn of NYPD's Emergency Service Unit (ESU) noted, "These are the most difficult cases officers will handle."

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1 Associated Press. (2024) LETHAL RESTRAINT, An Investigation documenting police use of force. https://apnews.com/projects/investigation-police-use-of-force/

2 Reese Dunklin, Associated Press (March 28, 2024), *Key findings from AP's investigation into police force that isn't supposed to be lethal.* Key findings from AP's investigation into police force that isn't supposed to be lethal | AP News.

3 See PERF Trending, (March 23, 2024) *California banned the term "excited delirium." Will it make a difference?* https://www.policeforum.org/trending23mar24

4 PERF Trending, (June 29, 2024) *Reducing restraint-related deaths.* https://www.policeforum.org/trending29jun24

5 See Acknowledgements for List of Participants. NOTE: Although unable to attend the meeting, Seth Stoughton contributed to this work as a subject matter expert before and after the meeting.

6 See e.g., PERF Guiding Principles On Use of Force (2015). https://www.policeforum.org/assets/30%20guiding%20principles.pdf

At our meeting, we agreed that the term "**medical-behavioral emergencies**" (MBEs) describes these cases since they generally involve a person experiencing a medical issue (often drug-induced or drug-enhanced) that presents to police as a behavioral issue.[7] In other words, police often perceive a person displaying willful, non-compliant behavior rather than recognizing that the person is in potential medical distress. As explained more fully in our recommendations, **in MBEs, police must view the person they are dealing with as a patient in need of medical care rather than a person intentionally defying directions**.

Working through the issues surrounding restraint deaths, our group largely agreed on the following 15 principles.[8] They are best practices that can be employed during nearly any incident, *not only MBEs*. However, during MBEs in particular, they can make the difference between life and death. And while saving lives is the goal of this publication, following these principles may also protect officers by giving them the necessary guidance to best handle these challenging cases.

Best,

Chuck Wexler

Chuck Wexler
PERF Executive Director

7 There was also a recognition that providing a name makes it easier for police to learn about and recognize MBEs, develop policy, train, and employ the safest practices for handling them.

8 Unless quoted, no information contained in this publication should be viewed as a direct attribution to any person involved in this project. Further, there should be an understanding that exceptional circumstances may require well-trained police officers to exercise sound judgment and deviate from this guidance.

PRINCIPLES

1. Identify Warning Signs of a Medical-Behavioral Emergency.

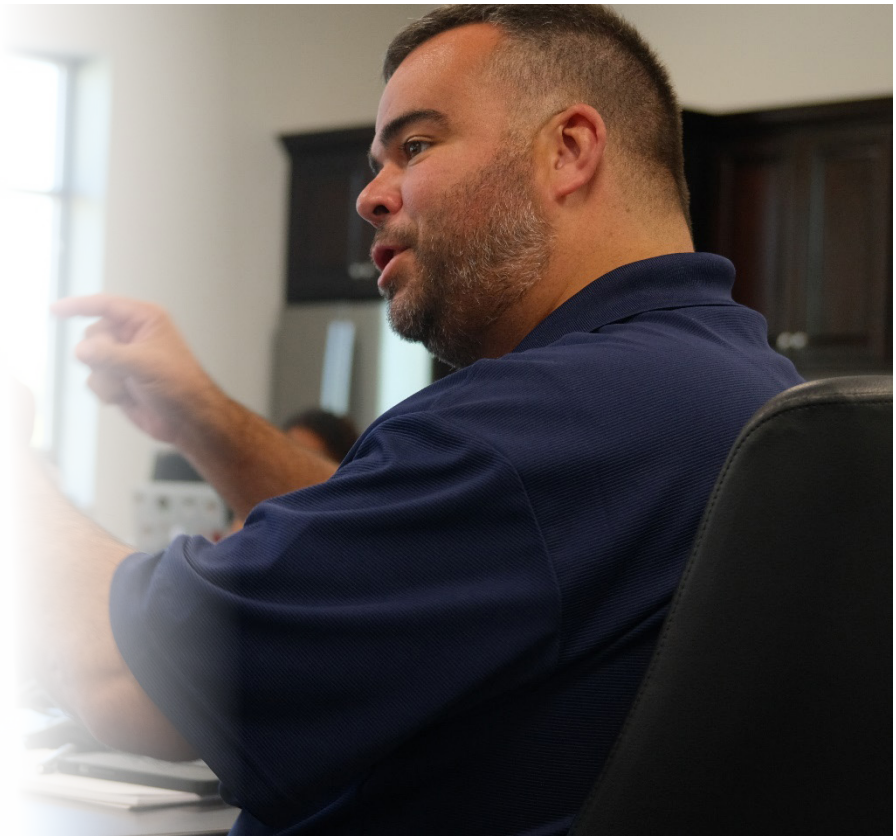
- *Police need to know that certain characteristics can signal an MBE and that the person involved may be disproportionately vulnerable to death if restrained.*

- *Learn to identify these incidents as potential medical emergencies immediately.*

Medical-behavioral emergencies (MBEs) are incidents in which a medical situation (often drug-induced or drug-enhanced) is generally misinterpreted as a behavioral issue. Dispatchers and law enforcement officers do not diagnose medical conditions, nor should they. However, our group agreed that certain characteristics that a 911 caller may describe to a call taker or that officers may observe at a scene should serve as warnings that the incident potentially involves an MBE. This is important because if it is an MBE, the coordination referenced in PRINCIPLE 2 needs to kick in, and everyone involved must understand that the person at issue may have a disproportionate risk of death if restrained. Restraint can contribute to death in a non-MBE situation, but the group assembled at our meeting agreed that the risk of death appears to be disproportionately greater when police restrain people with the characteristics noted.

It is so important to hit home on early recognition of these signs, so that we can get early EMS and hospital involvement. It needs to be a teamwork approach, and the first step is training people to recognize what they're dealing with and appropriate intervention techniques.

— Sergeant Jason Callinan, Cambridge (MA) Police Department, Registered Nurse



If a person displays the following traits, and especially if they display several, dispatchers and first responders should recognize that the incident may involve an MBE:

- Extreme agitation
- Erratic/irrational behavior
- Publicly naked or insufficiently attired for the weather[9] and/or sweating profusely
- Paranoia and delusional behavior
- Pain tolerance
- Heavy and/or rapid breathing
- Police have *actual* knowledge that the person has consumed drugs, especially stimulants (e.g., cocaine, PCP, and methamphetamine)
- Obesity

Importantly, an MBE does not signal that the person involved *will* die during a police encounter, whether or not they are restrained.[10] But an MBE does signal a potentially heightened vulnerability to death if restrained, and those called upon to deal with such a person should be aware of this heightened risk so that they can proceed in an *informed* manner.

9 It would seem reasonable that a 911 call for a person naked in public, other than during an obvious prank-like situation, should always trigger an MBE response, especially if the individual displays other characteristics such as "shouting incoherently" (i.e., paranoia/delusion) and walking in and out of traffic (i.e., irrational behavior).

10 The Associated Press series, referenced in fn1, noted that roughly 1,000 people died during or after police restraint over a ten-year period. While data in this area continue to emerge and there are no accurate estimates of the number of people restrained by police each year, the number of fatalities during or after restraint (~100/year) obviously represents a small fraction of the total number of people restrained by police each year. This publication aims to further reduce the number of deaths.

2. Plan and Develop Protocols for a Coordinated Medical-Behavioral Emergency Response.

- These are high-risk critical incidents.

- Police, fire, EMS, and dispatch leaders must plan for on-scene coordination and collaboration.

- Once details of a coordinated plan/policy have been agreed upon, stakeholders must engage in scenario-based training together.

MBEs are critical incidents and require an exceptional amount of coordination. **Dispatchers, police officers, EMS, and even emergency room personnel need to work together *before* an incident takes place to determine how they will coordinate care *when* an incident takes place.** This involves collaboration at the local level, and relevant stakeholders must pre-plan and, ultimately, train together. Police and EMS must understand their roles and responsibilities ahead of time to avoid turf battles and misunderstandings on the ground. [See also PRINCIPLE 13: On-Scene Collaboration and Coordination between EMS and Law Enforcement]

In addition to determining how on-scene coordination will work during MBEs, pre-planning, discussions, training, and tabletop exercises can help each entity understand the parameters under which the others operate.

I've found that law enforcement officers often don't understand that EMS personnel are operating under clinical protocols and they're obligated to do and not do certain things. And those protocols are very jurisdictionally and geographically defined. They vary from place to place.

For example, law enforcement sometimes calls on EMS to check a person out to ensure they're okay to go to jail. But that isn't a path available to EMS in Maryland. They can take a person to a hospital, or the person can refuse treatment, but no checkbox allows EMS to say a person is cleared for jail.

– Theodore Delbridge, MD, MPH,
Executive Director of
Maryland Institute for Emergency
Medical Services Systems

While law enforcement and EMS are critical to pre-planning and coordination, they are not the only entities that need to be involved. For example, dispatchers need to be educated about warning signs of MBEs and to dispatch EMS and police simultaneously for these calls [See PRINCIPLE 1]. Dispatchers should also know to dispatch a supervisor to the scene of potential MBEs [See PRINCIPLE 7] and to direct units to respond without lights and sirens, if possible, to avoid escalating the situation [See PRINCIPLE 4]. Jurisdictions may also want to consider implementing systems in which dispatchers – or an automated system – remind officers, as they respond to potential MBEs, to use time, distance, and cover [See PRINCIPLE 3] and that, if possible, restraint should be delayed until EMS is nearby, staging, or on-scene [See PRINCIPLE 5].

These types of collaborative details and expectations are best worked out ahead of time, not on the fly when an MBE takes place. After vetting the issues and developing protocols, *EMS and police must train together.* This can take place in the academy or at in-service training. **The only way that on-scene control and coordination can improve is through greater education, coordination, and training ahead of time.**

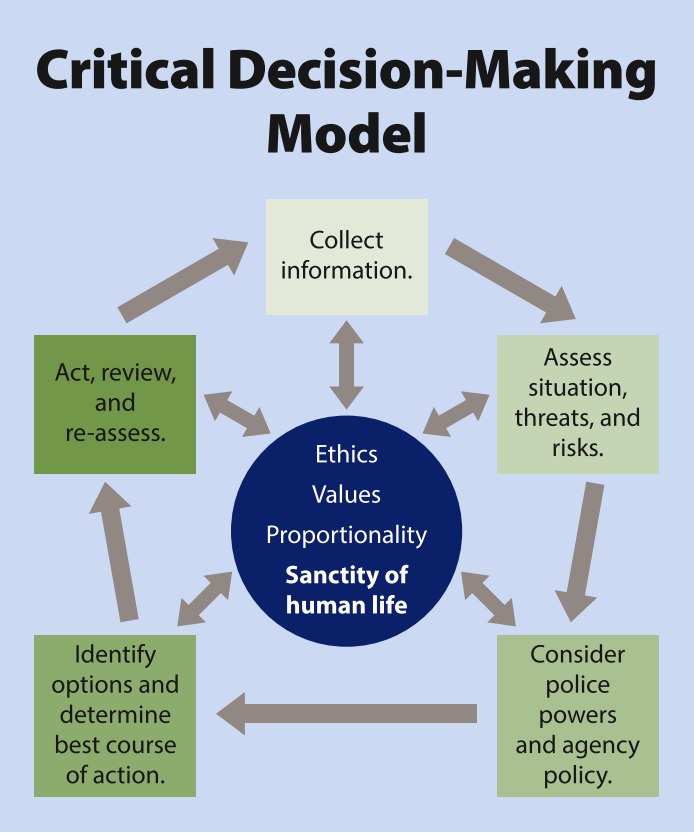
3. ICAT Principles Apply to Medical-Behavioral Emergencies.

- *Using the Critical Decision-Making Model and the principles of time, distance, and cover is vital during these incidents.*

ICAT: Integrating Communications, Assessment, and Tactics,[11] is PERF's evidence-based use-of-force training and helps officers defuse a range of critical incidents by using tactics that promote time, distance, and cover. Research has shown that implementing ICAT measurably reduces the use of force

The CDM is a thinking process. The moment you get the call, you want your officers to start thinking, what do I know? How can we best get this person into custody safely, considering the enhanced risks? And beyond that, how are we going to coordinate the care? This all goes back to ICAT and the CDM.

– Dan Alioto,
PERF Associate Deputy Director



11 ICAT: Integrating Communications, Assessment, and Tactics, https://www.policeforum.org/icat

and injuries to civilians and officers alike.[12]

Central to ICAT is the Critical Decision-Making Model (CDM), which helps officers assess situations and make safe and effective decisions. CDM skills are needed *most* during critical incidents like MBEs – from the moment an officer knows an incident may involve an MBE, that officer should be employing the CDM process.

4. De-escalate Wherever Possible, but at a Minimum – Don't Escalate.

- *Don't yell or repeatedly issue commands.*

- *Try to avoid flashing lights, loud noises like sirens, and other types of commotion.*

One of the least effective ways to calm a distressed or severely agitated person is to repeatedly tell them to "calm down" and "relax"– this never works and almost always has the opposite effect.

One of the things we see is cops, when they get spun up in these types of cases … they get tunnel vision, and they don't think about what they're saying. And they say things that never work when people say it to them, but they use it on other people. Two of the most common ones are telling people to "calm down" and "relax." That never works and usually makes the situation worse.

– John Nicoletti, Police Psychologist

There's a big difference between the suicidal, emotionally disturbed person and the severely agitated person. In both situations, I think it's good to say what an ER doctor says to every patient when we walk into the room. We say, "How can I help you today?" You'll know quickly whether the person can communicate or not.

– Stacey Hail, MD, Emergency Physician and Medical Toxicologist

12 Engel, Robin et al. Examining the Impact of Integrating Communications, Assessment, and Tactics (ICAT) De-escalation Training for the Louisville Metro Police Department: Initial Findings. International Association of Chiefs of Police-University of Cincinnati Center for Police Research and Policy, 2020. https://www.theiacp.org/sites/default/files/Research%20Center/LMPD_ICAT%20Evaluation%20Initial%20 Findings%20Report_FINAL%2009212020.pdf.

Instead, officers should try to engage in a way that doesn't escalate the situation and enables them to determine whether the person they are dealing with understands what is happening around them. A better way to engage with a person is to simply ask, "How can I help you?" or "What can I do for you?"

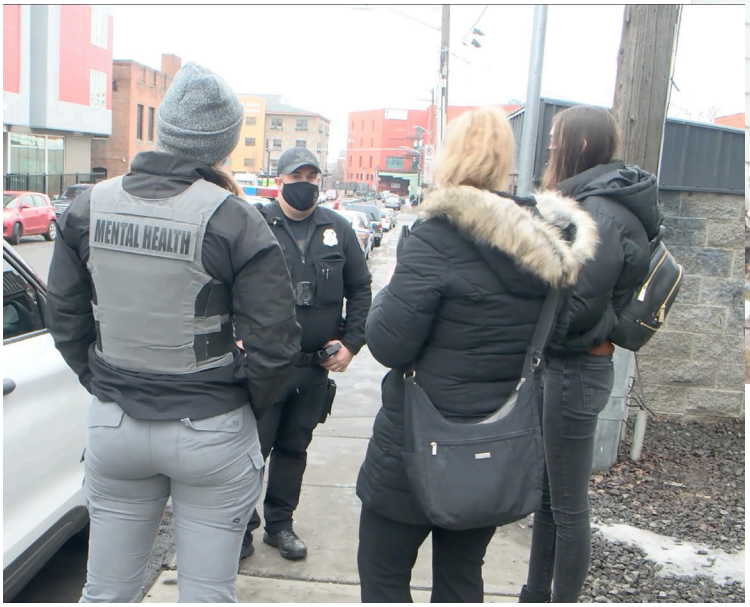
It's also best to minimize stimuli around a severely agitated or distressed person. Officers should work with dispatchers to have later-arriving officers and/or EMS respond without lights and sirens as they approach, if possible, since people experiencing MBEs are often already in an agitated and paranoid state.

5. Evaluate the Need to Immediately Restrain.

- *If a person is not at imminent risk of self-harm or harm to others and is not a significant risk of flight, restraint may not be necessary.*

- *If restraint is necessary, try to wait until EMS is on-scene or staging nearby.*

When responding to an MBE, or other behavior-related call, police need to make a careful determination about whether immediate restraint is needed at all. For example, if a person is naked and yelling in public, but contained in an area where they will not likely harm themselves or others, police should avoid going "hands-on" until they can activate a coordinated response,[13] if they need to go hands on at all. Of course, that type of scenario is different from one where a person is running into traffic or actively harming themself or others; in that type of circumstance, restraint will be necessary.



Members of the Spokane Regional Behavioral Health Unit (WA) conduct outreach and housecalls to connect with individuals who may be experiencing a mental health crisis. Source: Spokane Police Department

13 An example of such a response can be seen in this video from the Spokane Police Department: https://www.youtube.com/watch?v=OL_K6XAix6Q. Although the increasingly disfavored term "excited delirium" is used in the video, the incident is not spotlighted for the term officers use but for how they respond.

How to Restrain?

Jupiter (FL) Police Department officers compete in the 2024 annual Heroes Grappling Tournament, which included police, deputies, firefighters, and EMTs from across the state of Florida. Source: Facebook

This publication does not advise police on what tactic to use to restrain a person experiencing an MBE. Instead, PERF has focused on warning of the consequences of restraint and how to minimize the risks involved. However, we recognize that defensive tactics (DT) is another area where police want guidance; yet there is currently no clear consensus as to what the best tactics are.

Brazilian-Jiu-Jitsu-based DT has gained traction at many agencies and shows promise in helping officers safely restrain people quickly and then maintain them on their sides, rather than hold them with their chest to the ground.[14] PERF has also seen agencies develop promising practices for transitioning agitated patients onto backboards and removing restraints as safely as possible.[15]

However, the national discussion about the best way to restrain people, especially those who are violently resisting, lacks empirical evidence showing that agencies employing certain techniques have actually reduced their use of force-related injuries. Hopefully, this type of independently measured, data-driven evidence will be forthcoming and can further advance the field.

14 See Ali Bauman (July 1, 2024) *NYPD begins training officers in jiu jitsu. Here's why.* CBS News. https://www.cbsnews.com/newyork/news/nypd-brazilian-jiu-jitsu-rener-gracie/; Katja Ridderbusch (March 29, 2022) *Cops Are Turning to Jiujitsu to Curb Harmful Force, Boost Mental and Physical Health.* U.S. News and World Report. https://www.usnews.com/news/health-news/articles/2022-03-29/police-turn-to-jiujitsu-to-curb-dangerous-force-boost-mental-and-physical-health

15 See James J. Gerace and Michael W. Dailey, M.D. (January 10, 2023) *Safe Restraint of Agitated Patients*. FBI Law Enforcement Bulletin. https://leb.fbi.gov/articles/additional-articles/police-practice-safe-restraint-of-agitated-patients.

Police need to understand that restraint carries its own risks and should only be used if they've concluded that the individual is an immediate threat to themselves or could reasonably harm others.

— Victor Weedn, MD, JD, former Maryland Chief Medical Examiner

Officers need to weigh the risk of a person harming themself or others against the risk inherent in restraining a person exhibiting signs of an MBE. As noted in PRINCIPLE 3, using CDM skills is critical. Officers should not immediately restrain a person exhibiting signs of an MBE because that person is a *theoretical* flight risk or may *hypothetically* cause harm. During MBEs, speculation about what is *theoretically* possible should give way to what is *reasonably* possible. **If a person is reasonably contained, officers should hold off restraining them until EMS has arrived and the response can be coordinated; this requires a weighing of risks**.

6. Multiple Electronic Control Weapon (ECW) Applications May Increase the Risks Associated with Restraint.

- *The manufacturer's warnings indicate that certain people may be at a heightened risk of death if subjected to ECW exposure.*

- *When an ECW is used, the number of applications should be communicated to the EMS team.*

In 2006, PERF, in conjunction with the Bureau of Justice Assistance (BJA) and the Office of Community Oriented Policing Services (COPS Office), issued one of the first publications concerning ECWs - *Conducted Energy Devices: Development of Standards for Consistency and Guidance.*[16] Then, in 2011, PERF and the COPS Office jointly released a new set of ECW guidelines.[17]

Yet even as ECWs have become ubiquitous in law enforcement, they are not without risk, and during MBEs, that risk must be weighed carefully. The manufacturer's own literature acknowledges the potential dangers of using ECWs in certain circumstances. The 2022 Taser Safety and Health Information Warnings, released by Axon Enterprise, Inc., contain a warning about "Particularly Susceptible Individuals." People experiencing an MBE, as defined in this publication, would fit within the manufacturer's definition of Particularly Susceptible Individuals. That warning is reproduced on the following page. [18]

16 *Conducted Energy Devices: Development of Standards for Consistency and Guidance* (2006). https://www.policeforum.org/assets/docs/Free_Online_Documents/Use_of_Force/conducted%20energy%20devices%20-%20development%20of%20standards%20for%20consistency%20and%20guidance%202006.pdf

17 *Electronic Control Weapon Guidelines.* https://www.policeforum.org/assets/docs/Free_Online_Documents/Use_of_Force/electronic%20control%20weapon%20guidelines%202011.pdf

18 The entire document may be accessed and reviewed at: https://apnews.com/projects/investigation-police-use-of-force/static/58e02552aa31c6e4f51bcf129f6a9bc5/taser_le_warnings.pdf

Particularly Susceptible Individuals. Include those who are already physiologically or metabolically compromised due to heart disease, asthma or other pulmonary conditions, and people suffering from excited delirium, profound agitation, severe exhaustion, drug intoxication or chronic drug abuse, or over-exertion from physical struggle.

In human studies of electrical discharge from a single completed circuit of up to 15 seconds, the physiologic, metabolic, and stress hormone changes were comparable to or less than changes expected from physical exertion similar to struggling, resistance, fighting, fleeing, or from the application of some other force tools or techniques.

This acknowledgment of risk does not mean that ECWs should not be used to safely restrain a person, especially if the alternative is a protracted physical altercation. However, the heightened-risk warning is something officers should be aware of because it necessitates weighing risks.

There will be times when the ECW is the best option to take a person into custody and other times when its use should be viewed with extreme caution. **If the response to an MBE is coordinated** [PRINCIPLE 2] **and the restraint can be reasonably delayed** [PRINCIPLE 5]**, it is better not to use the ECW or any other means to restrain the person until EMS is on scene**. But delaying restraint will not always be possible.

If an ECW is used to obtain custody of a person experiencing an MBE, caution should be given to the number and duration of deployments. And, if EMS is not on-scene, the number and duration of deployments must be clearly communicated to EMS when they arrive.

It boils down to balancing risks. This is a split-second decision, where you're weighing the lesser of evils. If you have a heavy person [in an MBE situation] and you have five officers, and it's going to be a lengthy struggle, that's going to cause an incredible amount of metabolic stress in the person — much more than five seconds of a Taser. You have to ask, is the restraining process going to be so long and onerous that I actually do more damage than the potential damage that an ECW can cause?

— Jared Strote, MD, Emergency Physician

7. A Supervisor or Other Leader Needs to Take Charge.

- *These are critical incidents, and a supervisor or other person in charge can have a top-down stabilizing effect.*

Far too often, MBEs that result in death involve a collection of officers responding haphazardly to an incident with no plan and no leader coordinating the process. During any incident where an MBE is indicated, dispatchers should try to ensure that a supervisor is routed to the scene, which can have a top-down, stabilizing effect on the other officers. If a supervisor is not available, another officer needs to assume that leadership role.

A supervisor or other officer who takes a leadership position, possibly one who was not the first to respond to the MBE, can often bring an "outboard brain" or fresh eyes to an incredibly stressful situation. The tasks that such a person can coordinate include:[19]

- Confirming that EMS is in place (on-scene, staging, or on the way)
- Ensuring on-scene coordination among officers and between law enforcement and EMS [See PRINCIPLE 13]
- Requesting more personnel, as needed
- Coordinating traffic
- Making sure all officers have activated their body-worn cameras
- Advising officers that they see that a person has been restrained in the prone position for too long [See PRINCIPLE 9]
- Assigning a Patient Safety Officer [See PRINCIPLE 8]
- Stepping in if officers are making demands of a person that the person appears incapable of following, such as repeated demands to "calm down," "stop moving," and "relax" [See

Someone has to be in charge. Ideally, it's a supervisor, but whether it's a supervisor or not, somebody on-scene should take the lead and be in charge of these situations.

— Matthew Galvin, Deputy Chief, Operations Division, NYPD

19 As part of their planning and protocol development [See PRINCIPLE 2], police departments can generate a task response sheet that includes these and other tasks.

PRINCIPLE 10]
- Ensuring that officers' emotions remain in check and substituting officers in for others if needed [See PRINCIPLE 14]

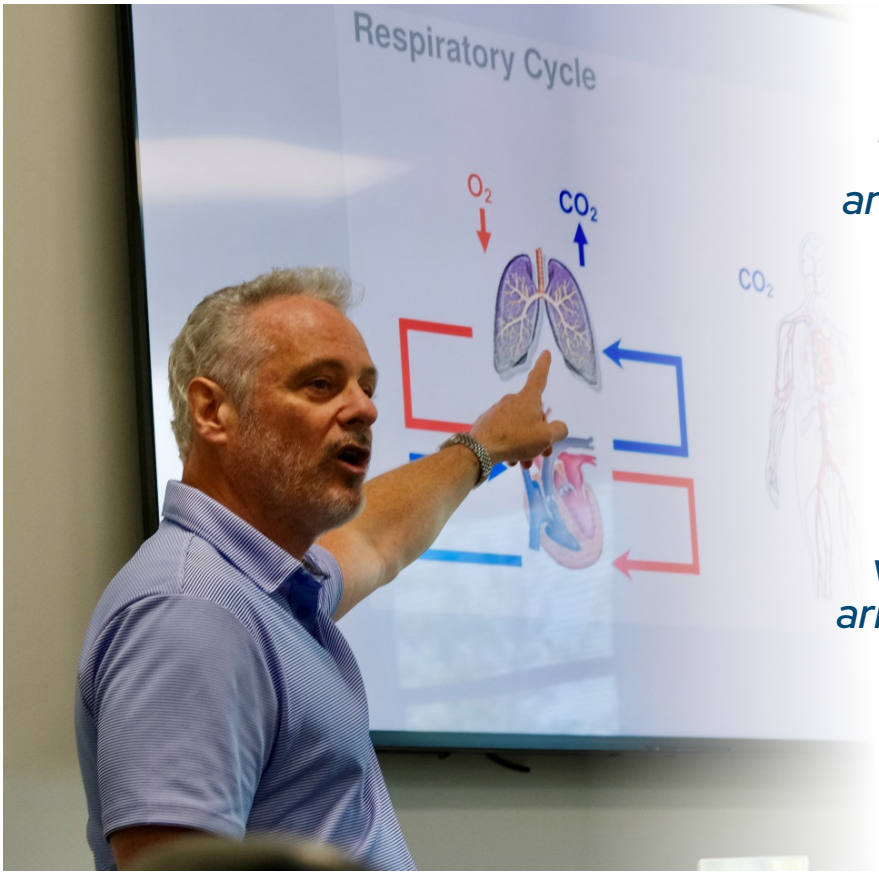
A supervisor is the most logical person to coordinate these tasks, but if a supervisor is not available, someone else needs to take charge. A designated person should be responsible for viewing the big picture and taking charge of the many moving parts to safely resolve the MBEs.

8. Designate a Patient Safety Officer.

- *Officers should continuously monitor a person's condition during and after restraint because unconsciousness can occur suddenly and advance beyond the point of viable resuscitation within seconds.*

- *Whenever possible, during a team restraint, one officer should be designated as the "Patient Safety Officer," with the responsibility to monitor the person's health and welfare during and after restraint.*

Unlike the supervisor or designated person in charge [See PRINCIPLE 7], whose duty is to monitor the entire incident broadly and take actions to help resolve it successfully, **another officer needs to focus exclusively on monitoring the subject's breathing and apparent consciousness — during and after the restraint.** Importantly, even after a person is moved out of the prone position, death can still take place.



What I see a lot is people who are kept in a prone restraint. They are no longer struggling, and no one's checking if they're breathing. When someone remembers to check, it's too late. Statistically, what's the best chance of recovery from a cardiac arrest? It's early recognition, early CPR, and EMS on the scene. But the very best way to avoid cardiac arrest is to get these people out of prone restraint as soon as possible [See PRINCIPLE 9].

— Alon Steinberg, MD, Cardiologist

The experience of those assembled at our meeting — who have collectively reviewed hundreds of fatal incidents — was that during most fatal MBEs, nobody was monitoring the person, and nobody recognized that they had become unconscious until it was too late.

If the Patient Safety Officer sees that the person has stopped breathing or exhibits a reduced level of consciousness, they should immediately advise all present so that additional steps can be undertaken, such as moving the person to a different position, starting CPR, or immediately involving EMS, to reduce the risk of further deterioration. **One often-overlooked part of these incidents is that if a person becomes unconscious and needs CPR, handcuffs need to be removed immediately.** The Patient Safety Officer should also be responsible for and ready to quickly remove handcuffs so that medical care can be provided swiftly.

9. Prone Restraint Carries Potential Risks and Should be Limited.

- *Once a person in the prone position is handcuffed, they should be moved to a position that promotes free breathing as quickly as possible - by placing and maintaining the person on their side or, if possible, in a seated position.*

The assembled experts agreed that while putting a person in the prone position (i.e., face down) is, currently, the most common and effective means of achieving custody (for purposes of this publication, "custody" nearly always correlates with being handcuffed), **a person should be removed from the prone position as soon as possible.**[20] This is a police-practices guide, not a scholarly medical review. However, most of those assembled at our meeting felt that restraining someone in the prone position can be dangerous, not because it impedes their ability to inhale oxygen, but because it interferes with their ability to effectively eliminate carbon dioxide, which can in turn lead to metabolic changes that may culminate in prone restraint cardiac arrest.[21]

During MBEs, officers tend to view handcuffing a prone-restrained person as their ultimate goal, often seeing it as the end of a stressful and exhausting encounter. This is why, once a person is in handcuffs, police routinely relax their vigilance; this is the worst thing they can do.

From the moment a prone-restrained person is handcuffed, officers must immediately shift their focus to getting that person out of the prone position. **It is often while people are handcuffed and in the prone position (frequently with officers holding them down) that they become unresponsive and die.**[22] It is therefore important that once a

Prone restraint is a law enforcement technique that is widely used – and even sometimes used by paramedics. It's used to gain immediate control. The point is to get the person out of that position once immediate control has been established.

— Eric Jaeger, JD, Paramedic, EMS Educator

20 Although expert opinion varies, most of those assembled at our meeting also noted that weight on a subject's back or side during prone restraint exacerbates the risk of deterioration. This includes weight placed anywhere on a subject's shoulders, upper back, or lower back.

21 See Victor Weedn, Alon Steinberg, Pete Speth. "Prone restraint cardiac arrest in in-custody and arrest-related deaths." J. Forensic Sci. 2022 Sep; 67(5) 1899-1914. https://pubmed.ncbi.nlm.nih.gov/35869602/.

22 This is not to suggest that people cannot or do not become unconscious at other points during interactions with police but based on the collective knowledge of our assembled group, in most fatal MBEs, the person becomes unconscious while in the prone position.

person is controlled–and importantly, control does not require complete compliance or thorough immobilization [See PRINCIPLE 11] – officers must make every effort to move them out of the prone position as soon as possible, by moving them onto their side.

It will almost always be challenging to move a person onto their side or into a sitting position during an MBE because these people are generally unable to remain still, may not comprehend what is happening around them, and can be highly agitated and erratic.[23] **But officers must make every effort to do so.**

10. Not Following Directions Does Not Always Mean Willful Non-Compliance.

- *Officers should expect that a person experiencing an MBE will not comply with their directions – before and after being restrained.*

During MBEs, police deal with people who are almost always non-compliant; if they communicate at all, it often involves paranoid or nonsensical language. People in this situation are generally not receptive to commands like "Put your hands behind your back" and "Step into my police car." This is why police go "hands-on" during MBEs – to get the person into custody and get them to the hospital.

If a person is largely incapable of understanding police commands, complying with police directions, and remaining still *before* officers restrain them, there is no reason to believe they

Irrational behavior is not necessarily non-compliance – so don't immediately act on it. Struggle after restraint isn't necessarily non-compliance either. Police need to know that.

– Tim Cameron, Colonel, Wyoming Highway Patrol, Former St. Mary's County (MD) Sheriff

23 A video of such an individual, which illustrates this point can be found here: https://vimeo.com/944179956/3740676bff?share=copy (link taken from the public, May 17, 2024 report from the Office of the New York State Attorney General, accessed at https://ag.ny.gov/sites/default/files/reports/osiris-mercado-23sep2021-report-final.pdf).

will suddenly become compliant, obedient, and immobile *after* police restrain them. And yet, this is generally what police expect, as evidenced by the repeated flow of "Stop moving!" and "Settle down!" commands frequently observed on restraint videos.

By recognizing that a subject who does not comply with directions before, during, and after being restrained may be incapable of doing so, officers can maintain perspective and reasonable expectations. If any officer observes that another officer is engaging in conduct that reflects unrealistic expectations, they should be prepared to 'Step Up and Step In' [See PRINCIPLE 14].[24]

11. The Goal is Control, NOT Complete Immobilization.

- *If a subject is controlled, they do not need to be completely immobile.*

- *Insisting that a restrained person "stop moving" does not work and is counterproductive.*

The goal of restraint during an MBE is to control a subject so they can receive medical care — first by EMS and later at the hospital. However, as noted above (PRINCIPLE 10), people experiencing MBEs are often incapable of following directions and remaining still. Furthermore, when people are restrained face down, their efforts to reposition themselves to breathe better (often referred to as "air hunger") can easily be confused with disobedience to orders.

Officers need to understand that they can't keep restraining a person until that person stops moving. Officers should be trying to reach a point where a subject can no longer harm people or escape, not some point of complete non-movement beyond that.

— Amanda Terrell-Orr, Strategic Initiatives Manager, Colorado Springs Police Department

24 As noted in PRINCIPLE 14, Module 7 of the ICAT Program is 'Step Up and Step In,' and guides officers through how to prevent problems by, for instance, intervening if another officer is about to make (or just made) a mistake or poor choice.

Law enforcement needs to understand that **the goal of restraint is not complete immobilization.** The goal of restraint is control — getting a person into a position where they can no longer reasonably harm themselves or others and are not reasonably likely to escape. This objective is almost always accomplished once the subject is handcuffed, especially when several officers are present.

Expecting and demanding complete stillness during restraints is unreasonable. Further, demanding that subjects "Stop moving!" creates a significant problem — if a subject becomes unconscious and does stop moving, officers often mistakenly interpret this fresh lack of resistance as compliance or fatigue rather than recognizing that the person has become unconscious. In other words, **sudden tranquility by an agitated subject is often viewed by officers as a sign of success when it should instead be viewed as a significant concern and potentially indicative of a devastating outcome.**

12. The Ability to Speak Does Not Mean a Person Can Breathe.

- *Statements about trouble breathing should be taken seriously as a potential sign of medical distress.*

- *A person can talk and still be in physiological decline.*

There is a persistent yet false belief in law enforcement that if a person can speak, that person can breathe and is, therefore, not in medical distress. **Police need to know that this belief is a false myth.**

The amount of air it takes to talk is a small fraction of the amount contained in normal, life-sustaining

Some officers think, "Because they can talk, they can breathe, right?" Wrong. Someone saying they can't breathe is a warning sign, which, if ignored, could ultimately end in death. The ability to speak words does not equal the ability to breathe.

— Bill Smock, MD, Police Surgeon, Louisville Police Department

human breaths.[25] And as some very public, viral incidents make clear,[26] **if officers wait until a person loses the ability to speak to take seriously claims that the person could not breathe, it may be too late to prevent a catastrophic physiological decline.**[27]

13. On-scene Coordination and Collaboration Between EMS and Law Enforcement is Crucial During MBEs.

- *EMS must be briefed, evaluate the situation, and determine the best next steps.*
- *Responsibilities for patient care should be transferred to EMS as soon as safe and feasible.*
- *Officers should be prepared to listen and act if their EMS partners indicate that a situation is unsafe.*

MBEs are hybrid situations where law enforcement and EMS both have significant, on-scene responsibilities and must work collaboratively toward the common goal of transporting the person safely to the hospital. From the moment EMS personnel arrive at the scene, the subject at issue is their patient. But

Most EMS providers want to know from officers that it's safe to approach the patient. And most officers know they have an obligation to tell EMS that the scene is safe and that it's safe to take custody. But officers must be prepared to receive guidance from EMS about patient care, especially if EMS sees officers doing something potentially dangerous.

— John Flynn, Sergeant, NYPD Emergency Service Unit, Paramedic

25 Anica C. Law MD, MS, Gary E. Weissman, MD, MSHP, Theodore J. Iwashyna, MD, PhD on behalf of the Pulmonary Critical Care Anti-Racism Working Group. "A Dangerous Myth: Does Speaking Imply Breathing?" Annals of Internal Medicine. 25 June 2020; Volume 173(9). https://www.acpjournals.org/doi/10.7326/M20-4186

26 See David K. Li "George Floyd told police he was struggling to breathe before an officer put a knee on his neck." NBC NEWS. 29 May 2020. https://www.nbcnews.com/news/us-news/george-floyd-told-police-he-was-struggling-breathe-officer-put-n1218556; Mike Baker, Jennifer Valentino-DeVries, Manny Frenandez, and Michael LaForgia. "Three Words. 70 Cases. The Tragic History of 'I Can't Breathe.'" NY Times. 29 June 2020. https://www.nytimes.com/interactive/2020/06/28/us/i-cant-breathe-police-arrest.html

27 Adapted from Law *et. al.*, *supra*.

unlike a person with a broken leg or chest pains, these patients are often dangerous to themselves and others, and so police also have a critical role.

EMS personnel must direct the medical care. Law enforcement should brief EMS on what they have observed and what they have been told about the subject, the number of ECW deployments and whether they were successful, whether the person was restrained in a prone position and for how long, the total amount of time the person has been restrained in any manner, whether the person has ingested intoxicants (if known), and any other information relevant to treatment. **Members of law enforcement should not recommend treatment protocols, such as sedation, to EMS personnel;** EMS should make those determinations independently, based on the totality of the circumstances.

Importantly, **if EMS sees law enforcement engaged in unsafe practices, they must feel empowered to 'Step up and Step in' and tell police that their actions are potentially dangerous.**

For example, some at our meeting related incidents during which EMS felt that police had been restraining a person in the prone position for too long while demanding that the person stop moving – but felt uncomfortable intervening. **Although many in the EMS community might feel inherent deference to law enforcement, that deference must always give way to safety when EMS observes potentially dangerous conduct.** EMS must feel emboldened to speak up if they believe patient care is being compromised, and law enforcement must be trained to listen to EMS in a non-defensive manner. As noted in PRINCIPLE 2, stakeholders must have discussions to establish expectations *before* MBEs occur.

I tell paramedics when you show up on the scene and step off the piece of apparatus, that individual is your patient. They may also be in police custody. The two things can overlap. It's not one or the other. And if they see the police managing an individual in an unsafe manner, they should professionally approach and say "Hey, can we get him up off his side? I'm worried about his breathing." The goal is to protect the patient, the police officer, and the paramedic from adverse outcomes.

– Eric Jaeger, JD, Paramedic, EMS Educator

14. Keep Emotions in Check and Be Ready to Step Up and Step In

- *These incidents can be physically and mentally exhausting, and when emotions are high, rational thinking is low.*

- *Officers need to monitor their own emotions, as well as those of others, to keep everyone safe.*

A fundamental part of ICAT training [See PRINCIPLE 3] is that when emotions run high, rational thinking runs low. As noted throughout this publication, MBEs can be among the most difficult, exhausting, and stressful calls an officer will ever face. The person at issue is often not responsive to normal de-escalation techniques, the incidents can take a long time to conclude, and some form of "hands-on" may be necessary to get the person to a hospital. Under these circumstances, the potential for abuse of power is greater than normal.

Officers need to be aware of these dynamics going into MBEs. The supervisor or other person in charge needs to closely monitor officers, especially when the subject is restrained, to ensure that emotions are kept in check and to remind the officers that, for instance, it is unreasonable to keep demanding that the subject stop moving or that statements about trouble breathing must be taken seriously. And, if it becomes necessary to "Step Up and Step In,"[28] any officer present must be fully willing and able to do so.

Officers should also expect and accept that if EMS sees officers acting in a manner that may endanger a person's well-being, EMS is also expected to speak up [See PRINCIPLE 13].

ICAT stresses maintaining your emotional control in situations. And being ready to step in when you see things might be happening with others. That's so important.

— Rico Gomez, Sergeant, Harris County Sheriff's Office

28 Module 7 of the ICAT Program is Step Up and Step In, and guides officers through how to prevent problems before they take place by, for instance, intervening if another officer is about to make (or just made) a mistake; it also stresses the importance of speaking up if an officer believes they have a plan to resolve a situation more safely.

15. Commit to Learning from Every Incident.

- *Agencies must be willing to analyze MBEs to determine whether improvements to process, policy, training, and equipment are necessary.*

After MBEs, there should be some form of after-action debrief to determine whether the incident underscores the need for greater coordination, or changes in policy, training, or equipment. At the agency level, this can take the form of an after-action debrief, but some form of "Monday Morning Quarterbacking" needs to take place as well.

As PERF has previously noted, agencies must begin having difficult conversations about critical incidents — conversations that are "not about blaming individual police officers [but are focused on] understand[ing] what happened in past incidents [in order to] prevent the next one."[29] These conversations are called Monday Morning Quarterbacking (MMQ). An MMQ following an MBE could involve a chief or sheriff going through the below questions with senior agency leaders, or sergeants running through the questions during a roll call briefing; the point is, the conversations need to take place:

- Did the agency have a plan and protocol and was it followed?
- Were there cues in the original dispatch that the incident might involve an MBE?
- Was EMS dispatched?
- Was a supervisor dispatched?
    - If not, was one person designated 'in charge of' the incident?
- Was the subject sufficiently contained such that restraint could have been delayed?
- From the moment the person was handcuffed, were the officers focused on *trying* to remove the person from the prone position?
- Did officers recognize that the goal of the incident was control, or did they keep demanding complete immobilization?
- Was a patient safety officer assigned?
    - Was that officer's exclusive focus on monitoring the subject's breathing and consciousness?
- What did the dynamic between EMS and law enforcement look like?
    - How could it improve?

The above questions represent some of the meaningful issues every agency should address after an MBE. **It's not about looking back to assign blame; it's about looking forward to make improvements.**

If an MBE involves multiple-system failures, such as problems with dispatch, police, EMS, and/or the local health care provider, those involved should consider a sentinel event review (SER). As Cornell University Government Professor Joseph Margulies has written:

> *[A Sentinel Event Review] takes the broadest view of an event to ask … how it came to be and what might be done to prevent its recurrence. It brings together the widest range of stakeholders to examine all the biases, incentives, relationships, and norms employed by all the actors whose conduct made the outcome incrementally more likely. It undertakes this examination candidly and openly, without blame or recrimination, driven solely by a shared desire to see that nothing like this ever happens again.*[30]

29 PERF Trending (February 4, 2023), *Monday Morning Quarterbacking the Memphis Incident.* https://www.policeforum.org/trending4Feb23

30 Joseph Margulies, February 16, 2023, "For Any Good to Come of It, We Must Judge the Murder of Tyre *Nichols in a Forgiving Spirit*," Retrieved from Justia: https://verdict.justia.com/2023/02/16/for-any-good-to-come-of-it-we-must-judge-the-murder-of-tyre-nichols-in-a-forgiving-spirit (emphasis added).

For example, after the Tucson (AZ) Police Department experienced two restraint-related in-custody deaths, all relevant stakeholders engaged in the SER process. The report that followed was comprehensive, identified a great number of factors (within and outside of the police department) that contributed to the deaths, and put forth many recommendations for improvement.[31]

Finally, agencies that safely resolve MBEs should debrief those as well. If a tragic incident occurs, it's helpful to credibly tell the community that it was an anomaly and, with facts, show how the agency has done everything possible to avoid these types of outcomes. Further, agencies should consider ways of sharing safe and successful MBE resolutions broadly with the field.[32] All law enforcement agencies benefit from reviewing other agencies' tragic *and* successful incidents and outcomes — and learning from both.

Modern police organizations have a professional obligation to continually review and enhance their public safety efforts. Agency leadership should study and learn from critical incidents, as well as those incidents that could have become problematic, those near-misses and officer successes. Open discussions with rank-and-file officers about incidents at the agency and elsewhere can help set peer expectations, facilitate more effective supervision, and contribute to a culture of continual improvement.

— Seth W. Stoughton, Professor of Law
University of South Carolina
Joseph F. Rice School of Law

31 *Report of the Tucson Sentinel Event Review Board (SERB)on the Deaths in Custody of Mr. Damien Alvarado and Mr. Carlos Adrian Ingram-Lopez* (September 18, 2020). https://www.scribd.com/document/476600375/Report-on-in-custody-death-of-Damien-Alvarado-and-Carlos-Adrian-Ingram-Lopez#from_embed

32 For instance, agencies that have successfully implemented ICAT principles to safely resolve incidents, routinely share those incidents with PERF; in turn, PERF often adds those examples into its ICAT curriculum.

Managing an MBE Alone

It is much easier to safely resolve an MBE if several officers are present and available to coordinate the care and duties from start to finish, but that will not always be possible. When an officer is alone, safely resolving these incidents is more challenging, but there is guidance in this publication that officers working alone can use to mitigate the risk of harm.

First and foremost, lone officers should never forget the ICAT principles of time, distance, and cover as they carefully consider whether they can wait to restrain until others arrive or avoid restraining at all. Determining whether restraint is necessary will depend on the subject's condition and what they are doing when the officer encounters them. In any event, before going hands-on, the officer should activate their body-worn camera, advise dispatch that they have an MBE, and request additional backup, a supervisor, and EMS.

If a person is a threat to themself or others and the officer must go hands-on,[33] they should do so recognizing that the goal is to control the person so they can ultimately receive medical care – *not* to immobilize the person completely. Therefore, the officer should not make repeated and fruitless demands to "Stop moving!" or similar directives.

As difficult as it will likely be for a single officer to control an agitated subject without keeping that person in the prone position, the officer must try to take the subject out of the prone position as soon as possible. Importantly, if an event turns fatal, the involved officer will be judged on the reasonableness of their efforts–**making good faith attempts to move and keep a person out of the prone position, even if unsuccessful, will be judged differently than not trying at all.**

Throughout all of this, the single (and likely exhausted) officer will need to assume the role of both patient safety officer *and* supervisor. This means that beyond monitoring the subject to ensure breathing and consciousness, the officer must maintain radio contact to ensure that EMS and backup are on the way.

These will likely be among the most difficult calls an officer will ever deal with alone, but implementing the guidance in this report can help that officer know they have done everything they could to resolve it safely.

If a member of the Wyoming Highway Patrol responds to an incident, the next nearest car might be a half-hour away. Maybe more.

— Tim Cameron, Colonel, Wyoming Highway Patrol, Former St. Mary's County (MD) Sheriff

33 Depending on the officer's DT training and confidence level, this is likely the type of circumstance where ECW deployment is preferable to a prolonged take-down attempted by a single officer; as noted in PRINCIPLE 6, using ECWs involves weighing risks.

CONCLUSION

The use of force, including restraint, continues to be a defining issue in policing today. Police routinely ask for guidance about how best to reduce the risk of restraint-related death, and through this publication, PERF seeks to move the field forward.

Simply put, the guidance outlined in this publication can save lives. Our SMEs, collectively having reviewed hundreds of restraint-related deaths, agreed that most of the principles outlined in this report are consistent blind spots for police engaged in stressful incidents that include restraint. Over and over, many have seen officers neglect to turn people onto their sides once handcuffed, insist on immobility instead of control, fail to monitor a person's breathing closely, and, at times, fail to take seriously statements that a person cannot breathe. Poor coordination and communication between dispatchers and officers, dispatchers and EMS, and officers and EMS are also regular occurrences during fatal, restraint-related incidents.

Employing the fifteen principles in this report can help officers reduce the risk of restraint-related death, with the ever-present goal of protecting the sanctity of life. Every police chief, sheriff, trainer, officer, and any other person involved in these incidents should take the time to read these principles and put them to use. They can save lives.

Acknowledgments

This project was supported through the generous support of the Howard G. Buffett Foundation.[34] Howard Buffett, who previously served as the Macon County (IL) Sheriff, has supported PERF's efforts to reduce fatal police uses of force since 2015, when he traveled to Scotland with a PERF delegation. The purpose of the trip was to study how police in Scotland, who generally do not carry firearms or ECWs, resolve incidents involving people armed with knives or other weapons, but not guns.[35] ICAT emerged from the knowledge gleaned from that trip as well as subsequent input from officers around the country. Mr. Buffett has continued to support efforts to train officers and reduce fatalities by building PERF's dedicated ICAT training facility in Decatur, Illinois.[36] PERF thanks Howard Buffett and the Howard G. Buffett Foundation for their generous support.

This report was written by PERF Deputy Director Jennifer Sommers, who reviewed many restraint-related fatalities in her capacity as Deputy Chief and Upstate Supervising Chief at the New York State Attorney General's Office of Special Investigation; relevant to this work, Ms. Sommers also holds a master's degree in toxicology. Director Tom Wilson and Associate Deputy Director Dan Alioto, who have trained thousands of officers in ICAT and how to avoid force whenever possible, were highly involved in planning the project and the meeting and reviewing the final report. Senior Research Assistant Caleb Regen provided invaluable assistance with all aspects of this project.

Below are the non-PERF subject matter experts who joined us in Decatur to discuss this important topic. It was truly difficult to distill the experiences of these outstanding specialists down to one paragraph. I cannot thank them and everyone else involved in this work enough. This project will save lives.

Best,

Chuck Wexler
PERF Executive Director

34 https://www.thehowardgbuffettfoundation.org/

35 Al Baker, New York Times (December 11, 2015), *U.S. Police Leaders, Visiting Scotland, Get Lessons on Avoiding Deadly Force.* https://www.nytimes.com/2015/12/12/nyregion/us-police-leaders-visiting-scotland-get-lessons-on-avoiding-deadly-force.html

36 See PERF Trending (May 20, 2023) *An important new step in the evolution of ICAT.* https://www.policeforum.org/trending20may23

Subject Matter Experts

Jason Callinan, Sergeant, Cambridge (MA) Police Department

Sergeant Jason Callinan has been with the Cambridge (MA) Police Department for 16 years and is currently assigned to the Family and Social Justice Section focusing on unhoused populations, substance abuse, and mental health issues. He also has over 18 years of experience working in Boston-area hospitals as a registered nurse in the emergency room. This has given him extensive experience related to medical and psychological emergencies. He is also a national registered paramedic. After obtaining his undergraduate degree from the University of New Haven, he furthered his post-graduate education at Simmons College for Nursing. He also obtained master's degrees in nursing education and criminal justice from Salem State University. He has qualified as an expert witness in Massachusetts in over 100 cases covering matters involving intoxication, vehicular homicide, human trafficking, and sexual exploitation.

Tim Cameron, Colonel, Wyoming Highway Patrol

Colonel Tim Cameron now serves as Wyoming's fourteenth Highway Patrol Administrator. He began his law enforcement career with the St. Mary's County (MD) Sheriff's Office in 1980 and ultimately became the elected Sheriff on November 7, 2006. Colonel Cameron is a graduate of the National Sheriff's Institute, the FBI`s Law Enforcement Executive Development course, the Maryland Police and Corrections Training Commissions Leadership Challenge, PERF's Senior Management Institute for Police, the Naval Postgraduate School's Center for Homeland Defense and Security, and the Wyoming Law Enforcement Academy. He obtained his bachelor's and master's degrees in management from the Johns Hopkins University; he is also a graduate of its Police Leadership Program.

Theodore R. Delbridge, MD, MPH, Executive Director, Maryland Institute for Emergency Medical Services Systems

Dr. Delbridge is an emergency physician. He is Executive Director of the Maryland Institute for Emergency Medical Services Systems, coordinating the statewide EMS system. He is also Professor Emeritus of Emergency Medicine at East Carolina University Brody School of Medicine, and a fellow of both the American College of

Emergency Physicians and the Academy of Emergency Medical Services. Dr. Delbridge is a graduate of Eastern Virginia Medical School.

John Flynn, Sergeant, NYPD

Sergeant John Flynn has been a member of the New York City Police Department for over 27 years. He has worked in patrol precincts as an officer and sergeant and has spent over 18 years assigned to the NYPD Emergency Service Unit (ESU), now serving as an ESU sergeant. He is assigned to ESU's Specialized Training School where he supervises initial entry training and in-service training for members of ESU, as well as its Tactical Paramedic Program.

Sergeant Flynn has extensive operational experience in tactical assignments, technical rescue, helicopter rescue, and WMD incident response. His tactical expertise includes warrant execution, active shooters, hostage situations, barricaded subjects, and persons in crisis. He has developed and delivered training for patrol and SWAT officers nationwide. Sergeant Flynn, an experienced volunteer firefighter and nationally registered paramedic, holds a bachelor's degree in criminal justice from St. John's University and a master's degree in public administration from Marist College.

Matthew Galvin, Deputy Chief, Operations Division, NYPD

Deputy Chief Matthew Galvin joined the NYPD in July 1988 and has served in various Patrol commands throughout NYC, the Narcotics Division, the Emergency Service Unit, and Transit Borough Bronx/Queens. Chief Galvin is the current NYPD Operations Division's Commanding Officer, having previously commanded the Transit Borough Bronx/Queens and serving as Executive Officer of the Emergency Service Unit as well as the 100 and 106 Precincts in Queens, NY. Deputy Chief Galvin holds a Bachelor of Science degree in Public Administration from the State University of New York, and a Master of Arts degree in Criminal Justice from John Jay College of Criminal Justice. He is a 2004 graduate of the FBI National Academy, a 2016 graduate of the Police Management Institute at Columbia University, and a 2021 graduate of PERF's Senior Management Institute for Police.

Jose "Rico" Gomez, Sergeant, Harris County (TX) Sheriff's Office

Jose "Rico" Gomez has been with the Harris County Sheriff's Office (HCSO) for over 17 years, starting as a detention officer before becoming a deputy in 2009. He was an early volunteer for the Crisis Intervention Response Team (CIRT) and played a key role in launching the agency's CIRT and CORE telehealth program for patrol. Promoted to Sergeant in 2020, Sergeant Gomez leads the Behavioral Health Training and Projects Unit, overseeing programs like CORE, Project Guardian/Lifesaver and other related behavioral health programs. He is a national trainer for the PERF in Crisis Intervention and ICAT and has secured over $500,000 in grants for behavioral health efforts. He has received numerous accolades national and internationally, including the 2023 State of Texas Law Enforcement Professional Achievement Award and the 2024 State of Texas Crisis Intervention Peace Officer of the Year.

Stacey Hail, MD, FACMT, Associate Professor of Emergency Medicine and Medical Toxicology

Stacey L. Hail, MD, FACMT is an Associate Professor of Emergency Medicine and Medical Toxicology at the University of Texas Southwestern Medical Center in Dallas, Texas. She currently serves as attending physician in the Parkland Hospital Emergency Department and the North Texas Poison Center. Dr. Hail obtained a Bachelor of Science in Chemistry degree from Southern Methodist University and a Medical Degree from the Medical College of Georgia; she completed her emergency medicine residency and medical toxicology fellowship at Parkland Hospital in Dallas, Texas.

Dr. Hail has a prolific forensic toxicology practice and has served as an expert witness for attorneys throughout the United States, testifying in over 50 federal and state court cases. She has reviewed hundreds of cases for the Department of Justice regarding federal drug crimes. Her toxicology interests include methodology for cause-of-death determinations, sudden death in custody, and the national opioid epidemic. Dr. Hail has also

provided toxicology commentary for local and national news venues, including Dateline NBC and CourtTV, and for documentaries on the National Geographic channel, the BBC, and the Oxygen channel.

Eric Jaeger, True North Group

Eric Jaeger, JD, NRP is an EMS educator, attorney, and RSI paramedic. Eric lectures extensively on EMS topics and has presented at multiple national and state conferences, including EMS World and NAEMSP. A key focus of his work is reducing the risk of death associated with the restraint of agitated individuals. He is a resource for the news media and has developed updated EMS protocols on restraint and sedation. He earned his BS in Computer Science from MIT and his Law Degree from Boston College Law School.

For nearly 20 years, he has focused on medico-legal issues, including restraint, consent, and patient competency and capacity. Until recently, Eric served as the EMS Educator at Exeter Hospital in Seacoast, New Hampshire, where he was responsible for educating Exeter's ALS Intercept paramedics, emergency department staff, and surrounding EMS agencies.

Kevin Lutz, Director of the Office of Law Enforcement Professional Standards (OLEPS), New Jersey Office of the Attorney General

Kevin D. Lutz serves as Director of the Office of Law Enforcement Professional Standards (OLEPS) in New Jersey and has extensive experience as a law enforcement officer, specializing in police training and reform initiatives. He served in the United States Marine Corps and the Oaklyn (NJ) Police Department before joining the Camden City (later Camden County) Police Department (CCPD) in 2006. At CCPD he served in a variety of operational, investigative, and command assignments, ultimately attaining the rank of Captain. He served as the Chief of Police for the Rutgers University Police Department-Camden before his appointment to OLEPS.

Director Lutz has earned a national reputation as an expert in police reform focusing on de-escalation training, use of force, defensive tactics, and community engagement initiatives. In 2020, he testified before the Minnesota Police-Involved Deadly Force Encounters Working Group as an expert witness and subject matter expert. Lutz received his bachelor's and master's degrees from Fairleigh Dickinson University, and is a graduate of PERF's Senior Management Institute for Police. He has received numerous awards and commendations throughout his law enforcement career and continues to promote best practices in policing.

John Nicoletti, Ph.D, ABBP, Public Safety Psychologist, Nicoletti-Flater Associates

John Nicoletti, Ph.D., is a board-certified police and public safety psychologist. His main areas of specialization involve threat assessment, de-escalation of force, and mass violence trauma recovery. Most recently, Dr. Nicoletti was the recipient of a DHS grant to provide targeted violence and radicalization prevention training.

Bill Smock, MD, Police Surgeon, Louisville (KY) Metro Police Department

Dr. Bill Smock joined the Louisville Police Department in 1993 as its first SWAT team tactical physician and police surgeon. In 1994, he became the first physician in the United States to complete a post-graduate fellowship in Clinical Forensic Medicine. Dr. Smock has served as Assistant Medical Examiner with the Kentucky Medical Examiner's Office, Medical Advisor to the Louisville Division of the FBI, and Tactical Physician/Special Deputy US Marshal.

Dr. Smock advises and consults with the Louisville Metro Police Department and other law enforcement agencies nationwide about officer health-related issues, forensic medicine, and reconstructing officer-involved critical incidents. He has edited four textbooks on clinical forensic medicine and published more than 40 peer-reviewed chapters and articles on forensic and emergency medicine. He is an internationally recognized forensic expert and trains nurses, physicians, law enforcement officers, attorneys, and judges in many medico-legal topics. Dr. Smock, a graduate of the University of Louisville, School of Medicine, has received honors and awards from multiple colleges and universities, law enforcement agencies, and prosecutorial organizations.

Alon Steinberg, MD, Cardiologist, Cardiology Medical Associates, Ventura (CA)

Dr. Alon Steinberg is a Board-Certified Cardiologist practicing in California. He has been the Chair of the Division of Cardiology at Community Memorial Hospital in Ventura, CA for the last 15 years. He has served as an expert consultant for the Medical Board of California and provided critical testimony for the State of California in the case of Conrad Murray vs California in 2011. Dr. Steinberg has a deep interest in prone restraint deaths. He authored "*Prone Restraint Cardiac Arrest: A Comprehensive Review of the Scientific Literature and Explanation of the Physiology*" which was published in Medicine, Science, and the Law in 2021, and co-authored "*Prone Restraint Cardiac Arrest in in-custody and arrest related deaths*" in the Journal of Forensic Sciences in 2022. He has been a speaker at national meetings sponsored by the American Academy of Forensic Sciences, the National Association of Medical Examiners, the Institute for Prevention of In-Custody Deaths, and the International Association of Chiefs of Police. Dr. Steinberg, a graduate of the University of Texas Medical Branch School of Medicine, continues to advance the understanding of dangers associated with prone restraint.

Seth Stoughton, JD, Professor, University of South Carolina Joseph F. Rice School of Law

Seth Stoughton is a professor of law and the Faculty Director of the Excellence in Policing & Public Safety Program at the University of South Carolina Joseph F. Rice School of Law. A former officer and investigator, he has conducted academic research on policing for more than a decade, specializing in tactics, the use of force, and industry standards. He has published extensively in the area; his work is highly relied upon in the field and is frequently cited in law, criminology, and other disciplines. His first book, *Evaluating Police Uses of Force* (NYU Press, 2020), co-authored with Jeffrey Noble and Geoffrey Alpert, provides an in-depth analysis of the standards and principles that regulate the use of force. He frequently provides executive and supervisory training for police commanders and investigators. He is a frequent lecturer on policing issues; has regularly appeared on national and international media; has written about policing for *The New York Times*, *The Atlantic*, *TIME*, and other news publications; and has filed multiple amicus briefs to the Supreme Court. Seth has also served as an expert in both civil and criminal litigation, testifying both on behalf of and against officers.

Jared Strote, MD, Professor of Emergency Medicine, University of Washington

Dr. Jared Strote is a Professor of Emergency Medicine at the University of Washington. He practices clinically at Harborview Medical Center, Seattle's county hospital where incarcerated and in-custody patients are brought for acute medical care. For more than 20 years, his primary research focus has been injury prevention during law enforcement use-of-force, with a particular emphasis on conducted electrical weapons and unexplained deaths in custody; he has published many papers and textbook chapters on the challenges surrounding these issues. Dr. Strote, a graduate of Harvard Medical School, continues to work with the Seattle Police Department on harm reduction practices.

Amanda Terrell-Orr, Strategic Initiatives Manager, Colorado Springs Police Department

Amanda Terrell-Orr has over 25 years of experience as a professional staff member in law enforcement agencies. As the Strategic Initiatives Manager at the Colorado Springs Police Department (CSPD), Amanda holds an important role within the Chief's Executive Staff, providing invaluable guidance and expertise to senior leadership across a wide array of critical areas related to research, data-driven decisions, legislation, policy, accreditation, compliance, strategic planning, performance measurement, and transparency. She has successfully led diverse groups in developing, evaluating, and improving many programs and practices in law enforcement agencies. Amanda holds a bachelor's degree in psychology from Central College and a master's degree in sociology from the University of Colorado, Colorado Springs.

Victor Weedn, MD, JD, Forensic Pathologist

Victor W. Weedn, is a forensic pathologist and attorney. He has adjunct professorships at the George Washington University and the University of Maryland, Baltimore. He has worked as a medical examiner, crime laboratory

director, research scientist, and academic, including as a law school professor. He founded the military's DNA identification program and oversaw the Armed Forces Identification Laboratory (AFDIL). His lab identified the remains of Czar Nicholas II of Russia, the Branch Davidian conflagration victims in Waco, and later Michael Blassie, the Vietnam unknown of the Tomb of the Unknown.

Dr. Weedn holds a patent on latent fingerprint technology. He established the National Association of Medical Examiners' inspection and accreditation program and was the President of the American Academy of Forensic Sciences (AAFS) from 2015-2016, where he established the Academy Standards Board. He was detailed to the DOJ as the Senior Forensic Advisor to Deputy Attorney General Sally Yates, 2016-2017, and participated on the Scientific Advisory Board of the International Criminal Court Office of the Prosecutor in 2017 and 2018. Dr. Weedn, a graduate of the University of Texas, Southwestern Medical School, has published extensively and, most recently, has focused on arrest-related deaths.

About the Police Executive Research Forum

The Police Executive Research Forum (PERF) is an independent research organization that focuses on critical issues in policing. Since its founding in 1976, PERF has identified best practices on fundamental issues such as reducing police use of force; developing community policing and problem-oriented policing; using technologies to deliver police services to the community; and developing and assessing crime reduction strategies. Over the past decade, PERF has led efforts to reduce police use of force through its guiding principles on use of force and innovative Integrating Communications, Assessment, and Tactics (ICAT) training program.

PERF strives to advance professionalism in policing and to improve the delivery of police services through the exercise of strong national leadership; public debate of police and criminal justice issues; and research and policy development.

The nature of PERF's work can be seen in the reports PERF has published over the years. Most of these reports are available without charge online at http://www.policeforum.org/free-online-documents. All of the titles in the Critical Issues in Policing series can be found on the back cover of this report and on the PERF website at https://www.policeforum. org/critical-issues-series. Recent reports include *Transforming Police Recruit Training: 40 Guiding Principles* and *Lessons Learned from the COVID-19 Pandemic: What Police Learned from One of the Most Challenging Periods of Our Lives*.

In addition to conducting research and publishing reports on our findings, PERF conducts management studies of individual law enforcement agencies; educates hundreds of police officials each year in the Senior Management Institute for Police, a three-week executive development program; and provides executive search services to governments that wish to conduct national searches for their next police chief.

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