

Training, Policy, Product Warnings, and Science—Are They at Odds?

by John G. Peters, Jr., Ph.D., CLS*

Lawsuits against correctional and other law enforcement agencies often identify conflicts between and among agency training, agency policy, product warnings, and scientific studies. Many times, agency policies incorporate so-called "standards" that are not standards at all, but rather are only an organization's recommendation(s) about an issue. Placing them into a policy manual often raises these recommendations to de facto agency standards, but not constitutional standards. These so-called standards may also be at odds with scientific findings or manufacturer product warnings. Using two actual events to illustrate this ubiquitous conundrum and practice, this article will illustrate and diagnose how these variables (agency training, agency policy, product warnings, and scientific studies) can affect government entities.

Risk Management

Risk management focuses upon the identification of possible hazards and safety issues (problems), their root cause(s), and the development of organizational strategies to prevent them from occurring or recurring, or at the very least minimize their frequency and severity. As technology advances, its effect on correctional administrators' and managers' strategic integration of specialized technology, training, written policy, and operations is critical. Wisconsin attorney Gregg J. Gunta, former Milwaukee Assistant City Attorney and acting risk manager and current law enforcement defense attorney, says:

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After identifying the problem, the focus will shift to what is the worst case scenario (consequences), along with the potential loss levels...I was told by a Wisconsin law enforcement administrator that employee turnover, even if it is generational, will often result in a repeat of past problems, over and over again.

Current and past problems are not the only concerns in risk management. Changing technology often demands that administrators identify and discuss future risks. Two variables that are often overlooked in assessing risk are scientific studies and technology product warnings. Increasingly, these two areas are affecting the technological, tactical, medical, or correctional practice being reviewed and analyzed. Due to space limitations,

5. Identify mitigation strategies (e.g., re-training, rewrite policy).
6. Identify significant milestones (i.e., decision points).
7. Develop a monitoring/tracking/measuring mechanism to ensure that Steps 5 and 6 are progressing as planned.

Gunta cautions:

If administrators and managers fail to engage in this or a similar process on a regular basis, they will always be looking for something, because the root cause will never be identified. If the "real" cause is not identified, administrators and managers will face the same problem(s) over and over again.

Clearly, this is not a once-a-year or even a one-time event. The review of policy, training, science, and so forth is

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only two risk management issues will be discussed: one tactical (restraint procedures) and one technological (electronic control devices).

Template for Risk Identification

While there are many pathways for identifying risk, Attorney Gunta uses the following six steps, while management consultant and professor Dr. William D. Steeves, Jr., Ed.D., urges a seventh step for outcome measurement, namely:

1. Identify the problem(s).
2. Identify the root cause of the problem(s).
3. Identify the potential consequences (e.g., money and/or direct injury).
4. Identify the likelihood of the consequences (e.g., assess probability and loss levels).

a *process*, and not a *project* that is done one time and then put onto a shelf, never to be thought of again.

Change Versus Changing

Adopting the risk identification template and including a synthesis of science and product warnings may require a change of existing process and thought. Bottom line: change. According to motivational speaker and psychologist Dr. Charles Lowery, Ph.D., "No one is against *change*, but they are against *changing*." Remember: The only person not against change is the baby in a wet diaper.

Framing a problem or issue differently may require a change in approach, thought, personnel, or budget. The good

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news is that correctional administrators and managers can often resolve problematic issues while effecting positive change, with little or no money, while simultaneously minimizing municipal and individual exposure to potential loss and injury.

Step 1: Identify the Problem

Some problems are easier to identify than others, but the process must generally begin with the identification of a past, present, or future problem that may expose governmental entities, correctional administrators, or officers to potential loss (e.g., discipline, financial, etc.). Here are two confirmed examples:

1. An agency began a self-initiated internal investigation of an officer who reportedly permitted a handcuffed prisoner to remain in a prone position, which violated agency policy.
2. A prisoner died several minutes after receiving a fourth five-second shock from an electronic capture device (ECD). The cause of death as reported by the local media: being shocked four times with 50,000 volts from an ECD, which violated agency policy of limiting the frequency of ECD shocks to no more than three.

One of the first steps in this phase is to gather the event's facts and then identify the problem(s). The problem identification may also surface the need to conduct a review and comparison of agency training, agency written policy, product warnings, and science, and how they may relate to the facts. If agency training, policy, product warnings, or science do not support, parallel, or are in conflict with event facts, the employer (governmental entity), agency administrators, supervisors, trainers, and officers may be the target of discipline or litigation that can result in a varying array of potential losses. These conflicting variables can be expressed as:

$$T + WP + PW + S = EC$$

Where:

- T = training (past or present)
 WP = written policy of the agency
 PW = product warnings
 S = scientific findings
 EC = event conflict

Using this formula, event investigators must first identify the variable(s) that is

(are) in conflict with the event, and then determine if the variable(s) was (were) the root cause of the event (Step 2). An officer may not have violated a product warning or scientific finding, but may have violated an agency policy or agency training.

Remember: Perception will often replace reality, if left to prevail. Therefore, when the media are pressing for answers and spinning the event based upon limited facts and information, the agency's public information officer must provide accurate and timely information to the media while the internal review of the event is being undertaken.

Step 2: Identify the Root Cause(s)

In the first example, an officer permitted a handcuffed prisoner to remain in a prone (face-down) position that allegedly violated agency policy and possibly agency training. A subsequent review of the agency lesson plan on handcuffing and restraint disclosed that officers were instructed to not keep a handcuffed person in the prone position. The reason being that he could die allegedly from positional asphyxia. The fear of dying from positional asphyxia was the primary underlying reason behind the agency policy that prohibited handcuffed individuals from remaining in a prone position.

Positional Asphyxia. Positional asphyxia was a "label" some medical examiners attached to cases (in the late 1980s) in which an agitated and psychotic individual died during transport to the station, jail, or hospital, usually after being restrained, and often placed in a prone position. (Steven Karch, *Pathology of Drug Abuse* (4th ed., CRC 2009).) The seminal research findings published about positional asphyxia concluded that being hobbled or hog-tied while in the prone position was harmful, and possibly fatal, to the restrained person. (D.T. Reay, C.L. Fligner, A.D. Stilwell, and J. Arnold, "Positional Asphyxia During Law Enforcement Transport," 13 (2) *Am. J. of Forensic & Medical Pathology* 90-97 (1992); D.T. Reay, J.D. Howard, C.L. Fligner, and R.J. Ward, "Effects of Positional Restraint on Oxygen Saturation and Heart Rate Following Exercise," 9 (1) *Am. J. Forensic Med. & Pathology* 16-18 (1988); B. Burgeen, C. Krosch, V. Binkerd, and B. Blackourne, "Final Report of the Custody Death Task Force" (San Diego Police Dept. 1992); R.L. O'Halloran and L.V. Lewman, "Restraint Asphyxiation in Excited Delirium,"

14 (4) *Am. J. of Forensic Med. & Pathology* 289-295 (1993); D.L. Ross, "An Analysis of In-Custody Deaths and Positional Asphyxiation," *The Police Marksman* 16-18 (Mar./Apr. 1996); S.J. Stratton, C. Rogers, and K. Green, "Sudden Death in Individuals in Hobble Restraints During Paramedic Transport," 25 (5) *Annals of Emergency Med.* 90-97 (1995).)

Now, back to the example. After interviewing the involved officers, it was determined that after the prisoner was handcuffed in the prone position, the officers were attacked by others, forcing them to temporarily physically, but not visually, abandon the handcuffed, prone person. Because leaving a person in a prone position was a violation of agency policy and training, the officers involved were the targets of an internal investigation. There was also the potential for discipline, civil suit, and possible criminal prosecution.

ECD Deployments. In the second event, a prisoner died approximately 20 minutes after receiving a fourth five-second shock from an ECD. A review of the incident showed the officer who deployed the ECD followed agency ECD training, but may have violated a subsection of agency policy that limited the frequency of ECD deployments to less than or equal to three. The facts also revealed that the person continued to struggle violently with officers after being handcuffed, but calmed down upon the arrival of medical personnel. While medically evaluating the handcuffed person who was now supine (face-up) on a stretcher, the individual suddenly stopped breathing and was later pronounced dead.

So what are the root causes of these two events—violation of agency policy, violation of agency training, technology failure, or something else? Although these real-world situations may not yet have occurred in your correctional agency, the officers who were involved in these events know all too well that, at best, they faced an exhaustive and highly critical internal investigation and, at worst, faced termination from their agencies, criminal prosecution, and civil lawsuit.

Step 3: Identify the Consequences

Identifying the potential consequences of these two events may take time, with potential risks changing as more information is obtained and reviewed. In essence, the focus of Step 3 is to identify

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potential monetary losses, injuries, and other losses to the governmental entity, administrators, supervisors, trainers, and the inmate. This analysis also includes the *empirical probability* and the *subjective probability* of each consequence occurring. Jaisingh described empirical probability thusly: "The relative frequency probability of an event's occurring is the proportion of times the event occurs over a given number of trials." Subjective probability is "a measure of belief." (Lloyd Jaisingh, *Statistics for the Utterly Confused* 125-127 (McGraw-Hill 2000).) In other words, subjective probability will depend upon individual life experience, hence the suggestion for having several people involved in helping to identify potential losses.

Quantify Risk. While, according to Jaisingh, subjective probability cannot be used "to define the chance of an event's occurring because the value may be different for different people," there should be some numerical process to identify the variables, evaluate them numerically and quantify the potential for risk. For example, have the agency's administrator, manager, supervisor, trainer, lawyer, and risk manager give each identified variable a score of, say, 1 to 5, as to the likelihood of the occurrence. Each individual's score indicates that person's "threat level of risk." The scores would then be discussed until one score is derived for each variable, indicating the presumed likelihood of that variable's occurrence.

Payoff. If the empirical or subjective probability is estimated to be high (e.g., being sued by the person's estate or relatives), then the potential loss may also be estimated to be high. Conversely, if the probability is estimated to be low (e.g., the person was not injured, did not complain, etc.), then the potential loss may also be estimated to be low.

Two decision-making approaches that do not use probabilities include the *optimistic approach* and the *conservative approach*. (D.R. Anderson, D.J. Sweeney, and T.A. Williams, *An Introduction to Management Science* (8th ed., West Publishing 1997).) The optimistic approach "evaluates each decision alternative in terms of the best payoff that can occur," while the conservative approach examines each decision alternative from the *worst* payoff viewpoint. (Anderson et al., *supra*, at 579.) After the identification

of the consequences has been made, Step 4 is to identify the loss level.

Step 4: Identify Loss Levels

The identification of potential loss levels must be realistic. Loss levels may be based upon jury awards in similar events, defense costs, medical evaluations, psychiatric evaluations, economic evaluations, and other facts. One key to accurately identifying potential loss levels is to obtain all the facts regarding the event, which include, but are not limited to the following:

- Interviewing involved officer(s);
- Identifying and interviewing witnesses;
- Interviewing agency trainers;
- Interviewing the supervisors who supervised the involved officer(s);
- Reviewing agency policy; and
- Reviewing agency training.

If the involved officers did nothing improper, the loss level may be lower than if the involved officers violated agency training or policy. However, the loss level must also factor in the agency's training and policies, separate from the officers' actions, as the training or policy may have unintentionally created a *false (elevated) standard* that may be used to impale the officers, trainers, and administrators, which in turn may elevate the potential for a large loss. Make sure the governmental entity's risk manager is included in any review of potential loss levels, in addition to the entity's attorney, medical provider, and similar personnel and advisors.

Step 5: Identify Mitigation Strategies

Potential mitigation strategies include, but are not limited to the following:

- Retraining officers;
- Rewriting training documents;
- Rewriting agency policy;
- Seeking criminal charges on the involved personnel;
- Disciplining the involved personnel, including suspensions or termination; or
- A combination of these strategies.

The focus of Step 5 is what must be done right away. This can be tricky. If agency policy was inaccurate or if an officer violated training, the rewriting of policy or the retraining of the officer may

cause concern for governmental entity attorneys who often argue that such remedial actions may imply an admission of wrongdoing or error.

Clearly, Step 5 will involve several people, but the focus is to remedy the underlying root cause as reasonably, responsibly, and quickly as possible, before a similar incident occurs. Remember: Administrators and others have now been put on notice about the identified problem and may be labeled as being "deliberately indifferent" for their failure to remedy the root causes of the problem in a timely and reasonable manner. A more thorough discussion about deliberate indifference appears below.

Step 6: Identify Significant Milestones

Step 6 focuses upon the establishment of benchmarks for implementing the mitigation strategies. Benchmarks may include, but are not limited to the following:

- A date for the rewriting of policy;
- A date for the reissuing of agency policy;
- A date for the re-training of officers; and
- The setting of involved personnel suspension dates and termination dates.

When setting benchmarks, timeframes must be clear and realistic. According to Judge Plitt, it is very common that after investigations are concluded, the results are never reviewed with training personnel. (Emory Plitt, Jr., *Jail and Prisoner Legal Issues* (AELE 2009).) Judge Plitt makes it clear that anytime there is a review of any kind of an incident implicating potential liability (i.e., risk management), the results of the investigation or review should be forwarded to the training division personnel so it can be determined if any modifications should be made to training and when, or what can be learned from this event.

Step 7: Develop Monitoring/Tracking/Measuring Mechanism to Ensure That Steps 5 and 6 Are Progressing as Planned

Timely and routine feedback is necessary for the monitoring of progress. To help ensure such feedback, agency management must identify and develop

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a monitoring mechanism that will provide timely tracking and measurement of the progress that was identified in Steps 5 and 6. If there are deviations from the remedial plan, corrections should be made quickly, otherwise the entire corrective plan may become fractured at best or, at worst, fail.

Restraint Training and Policy

Recently, many correctional and other law enforcement administrators and risk managers are reviewing their agencies' training procedures and written policies regarding restraint procedures and their possible impact on positional asphyxia. The main focus from the administrator's viewpoint is to avoid a death from asphyxia and to compare what is being taught by agency instructors to agency policy and procedures. A sudden, in-custody death from asphyxia that appears to have resulted from restraint procedures that were taught or were in conflict with agency policy may subject involved officers to a criminal investigation, civil litigation, administrative investigation, and discipline. Agency lesson plans that contain the training officers received must be reviewed and compared to the facts of the sudden, in-custody death. Next, agency policy that directly or collaterally focuses on the sudden, in-custody death must be:

1. Reviewed;
2. Compared and analyzed to what officers have been/are being taught;
3. Compared and analyzed to product warnings; and
4. Compared and analyzed to scientific findings.

Law enforcement administrators are keenly aware of the positive role training and written policies can have on civil lawsuits and on administrative investigations. Documented prior training (instruction) is often enough to defeat a claim of deliberate indifference. (*City of Canton v. Harris*, 489 U.S. 378 (1989).) Judge Plitt defined deliberate indifference as:

1. A choice made from among various alternatives;
2. A knowing choice, usually made with some state of mind;
3. A choice made with some knowledge or appreciation of what the consequences of the choice will/might be;
4. A choice made with knowledge of a particular problem or situation; and

5. A choice made after some time to consider the choices available. (Emory Plitt, Jr., *Police Civil Liability and the Defense of Citizen Misconduct Complaints* (AELE 2006); Emory Plitt, Jr., *Police Use of Force: Law Instructor's Guide* (AELE 2008).)

Anticipating problems that will confront officers and training to minimize their discretion at the operational level are two roles of training that follow the need for training in specific areas. Written policies, too, can also demonstrate reasonable guidance to control employee behavior.

System-wide written policies, rules, and procedures not only assist administrators in their planning, organizing, directing, and controlling of their agencies and units, but also "minimize the likelihood of unintentional infringements on constitutional rights." (Emory Plitt, Jr., *Police Civil Liability*, supra.) Written policies, rules, and procedures are often used to defeat a plaintiff's claim of deliberate indifference and minimize liability.

Agency Restraint Training and Product Warnings

In the first example (positional asphyxia), the agency's policy prohibited officers from allowing a handcuffed and prone prisoner to remain in this position. As you recall, the policy was designed to minimize the risk of a prisoner dying from positional asphyxia. Since there was limited technology used in this event (i.e., handcuffs), the product warning that came with the handcuffs should not be ignored, as a manufacturer may have provided a warning about positional asphyxia, application, checking tightness, double-locking, etc. Agency policy must be compared to that product's warnings (do not forget to compare it to the product warning that is often included with the product, but which is rarely given to officers) to avoid inadvertent variances. If there are variances, the agency lesson plan must contain a reasonable rationale and explanation as to why these product warnings were not adopted or were only partially adopted. Recall the recommendation of Judge Plitt: Share the investigation findings with training personnel.

Science and Agency Policy

Peer-reviewed scientific findings must also find their way into training and policy documents. As you recall, the seminal research findings published about positional asphyxia referenced above

theorized that being hobbled or hog-tied was harmful, and possibly fatal, to the restrained person. Many restraint lesson plans (including customized lesson plans on restraint chairs) and agency policies have included these disproven theories about positional asphyxia. However, trainers and administrators who have failed to update lesson plans and written policies by removing these disproven theories have devised a *nonscientific, false (elevated) standard* that may create unintended liability for the employer (governmental entity), administrators, managers, supervisors, trainers, and the officers who were involved in an event in which policy was not followed.

Not Scientifically Supportable. Subsequent studies in the 1990s have scientifically shown these earlier theories are not scientifically supportable. (T.C. Chan, G.M. Vilke, T. Neuman, and J. Clausen, "Restraint Position and Positional Asphyxia," 30 (5) *Annals of Emergency Med.* 578-586 (1997); M.A. Schmidt, T. Snowden, and J. Clin, "The Effects of Positional Restraint on Oxygen Saturation and Heart Rate," 17 (5) *J. of Emergency Med.* 777-782 (1999); Tom Neuman, "Positional Asphyxia and How It Morphed Into Compressional Asphyxia," 2nd Annual Sudden Death, Excited Delirium, and In-Custody Death Conference, IPICD (2007).)

Dr. Steven Karch, M.D., FFFLM, former assistant medical examiner in San Francisco and internationally-renowned cardiologist and drug abuse expert, noted:

[T]he whole concept of positional asphyxia has been reviewed, and the underlying hypothesis (that death may occur simply as a result of restraint in a prone position) tested, as required by the scientific method. The results of these controlled clinical studies have discredited the theory. (Steven B. Karch, *Pathology of Drug Abuse* 139-140 (4th ed., CRC 2009).)

Other researchers note that:

Based on the data that currently exist, the hogtie, maximal restraint position (hobble), or the prone position appear to be no more physiologically disruptive than any other position and insofar as they protect the individual from harming him or herself (e.g., from aspiration) or others, they are from a medical point of view, perfectly

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acceptable position in which to restrain and transport violent and out-of-control individuals. (Tom Neuman, "Positional and Restraint Asphyxia," in D.L. Ross and T.C. Chan, eds., *Sudden Deaths in Custody* ch. 4 (2006).)

Based upon the latter research findings, Dr. Reay wrote that his original research on positional asphyxia was flawed and that "more recent studies using arterial blood gas determinations refute our earlier work regarding the hog-tied prone body position." (D.T. Reay, "Death in Custody," 18 (1) *Clinics in Laboratory Med.* 1-22 (1998).)

Restraint Chair Asphyxiation. Related to prone positional asphyxia is the issue of prisoners dying from asphyxia while secured in a restraint chair. The seminal 2008 clinical restraint-chair study underwritten by the Institute for the Prevention of In-Custody Deaths, Inc., of Henderson, NV, concluded that restraint chairs are safe and will not cause asphyxia when used properly. (G.M. Vilke, T.C. Chan, and T. Neuman (in press 2009).) Those agencies in which policy prohibits prone restraint are providing plaintiffs with an "arrow" to shoot at them, as well as at their administrators, trainers, and officers. If the plaintiff is a disgruntled officer who was terminated or disciplined for violating a policy that is unscientifically based, the governmental entity and its administrators and trainers are opening the door for potential litigation and liability. These are situations that can often be avoided by not training or writing policy that is in conflict with contemporary science. Remember: The goal is to remove "arrows" from the plaintiff's quiver, and not to provide the plaintiff with ammunition.

ECD Training and Policy

The second example focused on the agency's policy that limited ECD deployments to less than or equal to three. The policy was allegedly designed to minimize the risk of a prisoner dying from electrical shock. Unlike the first example that used limited technology, the focus here is squarely on the technology, in addition to agency training and policy. As before, agency policy must be compared to that product's warnings to make sure there are no variances. If there are differences, the agency lesson plan must contain a reasonable rationale as to why

the product warnings were not adopted. To date, there are no exact limitations on the number of ECD deployments or discharges in the leading ECD manufacturer's product warnings. (TASER International, Inc.; <http://www.TASER.com/legal/Pages/Warnings.aspx>.) However, there are numerous advisory publications that warn to limit ECD exposures to a range between one and three.

Product Warnings

To minimize their own liability and comply with laws and regulations, manufacturers have a duty to prepare written and/or visual information about products to educate consumers, minimize potential injury, and minimize manufacturer liability. In short, under United States product liability laws, a manufacturer can be held liable if it fails to adequately and effectively communicate safety information about its products to end users, such as law enforcement officers. (K. Ross, "Location of Warnings: On Product or in the Manual?," *In-House Defense Quarterly* (Sum. 2008); K. Ross, "The Duty to Warn Illiterate or Non-English Reading Product Users," *In-House Defense Quarterly* (Wint. 2008).) Manufacturer warnings often come in the format of a warning label or instructions. Law enforcement administrators, trainers, and investigators need to consider manufacturer warnings when developing written policy, developing training programs, and conducting administrative or other employee-involved investigations in which products were used by employees.

Violation of Product Warning Law. To show a violation of the law regarding product warnings, certain elements must be met, namely:

1. That the manufacturer knew or should have known the risk inherent in the product;
2. That there was no warning, or the warning was inadequate;
3. That absence of a warning made the product unreasonably dangerous; and
4. That a failure to warn was the cause-in-fact and proximate cause of the plaintiff's injuries. (E.F. Shaver, "Caution: How to Develop an Effective Product Warning," *Risk Management* (Jun. 2008).)

While each state may have additional specific elements in addition to the foregoing, keep in mind the manufacturer may have met its legal requirements by

packaging warnings with the product, but that the product receiving area of the government entity or the agency failed to pass along the packaged warnings. Dr. Andrew Dennis, D.O., attending surgeon in a Cook County (IL) trauma unit, noted that he has never seen the warnings that are packaged with an ECD get passed along to the end-user (officer), which may create unintentional liability on the municipality and its administrators, managers, supervisors, trainers, and officers. Some government entities, however, assign kitted ECDs, including product manuals, training information, etc. to individual officers to ensure that each officer receives all of the information shipped with the ECD.

Reasonable Danger. While law enforcement or the product manufacturer cannot possibly warn against that which the product does not cause or was not foreseeable at the time of manufacturing and/or shipping (scientifically knowable risks), warnings are to be based upon a generally acceptable foundation of scientific, medical, and/or other professional evidence of defect, proof, foreseeable use, and condition to some foreseeable degree of certainty or probability. Warnings, to be useful and/or valid, are not to be based on rumor, innuendo, speculation, myth, and unsubstantiated statements. Warnings focus upon potential "danger" that a reasonable user would have no reason to expect or anticipate. However, sometimes officers must intentionally deviate from a product's warning.

Firearms manufacturers note in their warnings never to point a firearm at a person. Unfortunately, law enforcement officers are often forced to point a loaded weapon at an individual and in some cases discharge it. To ensure there are no unreasonable disconnects between agency training, agency policy, and product warnings, agency trainers and administrators must note why employees are being trained to deviate from a manufacturer's warnings, and why this deviation is acceptable under certain conditions.

Third-Party Warnings

Agency policies should avoid being based on rumor, innuendo, speculation, myths, and unsubstantiated statements. On occasion, a well-intended organization issues a document about a particular law enforcement product that contains

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its viewpoint throughout the document. Administrators, managers, supervisors, and trainers must read these documents very carefully, as sometimes the document does not apply to a particular product, such as an ECD. One international law enforcement organization issued a document about ECDs, but, by its own definition, the document eliminated the leading manufacturer's ECD products. (*Model Policy: Electronic Control Weapons* (IACP 2005); *Electronic Control Weapons: Concepts and Issues Paper* (IACP National Law Enforcement Policy Center 2005).) Similar law enforcement organizations have issued documents about ECDs that contained language limiting ECD deployments, but there are no proven scientific bases for their recommended limitations. (See *PERF Conducted Energy Device: Policy and Training Guidelines for Consideration* (PERF Center on Force and Accountability 2005).)

Viewpoints, Not Standards. Organizational recommendations are not national standards, but are viewpoints. If an agency adopts a viewpoint and makes it a part of a mandatory policy, such action may inadvertently elevate the viewpoint to a level where a court factors it in as a variable to be considered in its constitutional right and reasonableness-of-force equation analysis. For example:

Assuming internal police guidelines are relevant to determining whether use of force is objectively reasonable, **Tennessee v. Garner**, 471 U.S. 1, 18-19 (1985), they are relevant only when one of their purposes is to protect the individual against whom force is used. Thus, if a police department limits the use of chokeholds to protect suspects from being fatally injured, **Maddox v. City of Los Angeles**, 792 F.2d 1408, 1414 (9th Cir.1986), or restricts the use of deadly force to protect suspects from being shot unnecessarily, see **Garner**, supra, at 18-19, such regulations are germane to the reasonableness inquiry in an excessive force claim. (**Gutierrez v. City of San Antonio**, 139 F.3d 441, 449 (5th Cir. 1998).)

In **Drummond v. City of Anaheim**, the court stated:

Although such training materials are not dispositive, we may certainly consider a police department's own guidelines when evaluating whether

a particular use of force is constitutionally unreasonable. (**Drummond v. City of Anaheim**, 343 F.3d 1052, 1059 (9th Cir. 2003).)

As the Fifth Circuit stated in **Gutierrez**:

[I]t may be difficult to conclude that the officers acted reasonably if they performed an action that had been banned by their department or of whose dangers in these circumstances they had been warned. (**Gutierrez v. City of San Antonio**, supra, at 449; see also **Scott v. Henrich**, 39 F.3d 912, 916 (9th Cir.1994) ("Thus, if a police department limits the use of chokeholds to protect suspects from being fatally injured... such regulations are germane to the reasonableness inquiry in an excessive force claim." (Internal citations omitted)).)

Admissible State Trial Evidence.

Agency policies, rules, and procedures are often admissible evidence in state trials, although they do not set the constitutional standards that apply in federal lawsuits for constitutional violations. Therefore, keep a "history file" on policies, rules, and procedures that shows what the agency provided prior to the current ones and why changes were made to prior training programs, policies, rules, and procedures. When an agency can explain and document why it made reasonable changes to training, policies, rules, and regulations, it can help others to better understand the bases for these changes.

ECDs and Science

Scientific studies often affect agency written policy, training, and manufacturer warnings. Too often, these are not developed with scientific findings in mind. Scientific studies use a systematic and structured scientific approach to arrive at their findings, and are often reported in peer-reviewed journals, scientific texts, presentations to peer groups, and dissertations. (John G. Peters, Jr., "Science and Logic Meet the Law," in M.W. Kroll and J.D. Ho, eds., *TASER® Electronic Control Devices: Physiology, Pathology, and Law* ch. 32 (2009).) How scientific studies, product warnings, training programs, and written agency policies dovetail will often depend upon how thorough a literature review was conducted by the person assigned to complete each of these tasks. A literature review is not scientific research, but does involve the identification of primary (peer-reviewed) and secondary

(Internet sites, articles in trade publications, etc.) literature that focuses upon the topic about which the individual is seeking knowledge. The failure to synthesize science, manufacturer warnings, and officer training into agency policy, rules, and procedures will usually result in a scientific and legal collision inside the courtroom, unless these areas are reasonably integrated at the onset.

Unfortunately, many agencies do not conduct this synthesis because they are ill-equipped to do it, or do not know how to do it. Whenever an agency adopts new technology or products, manufacturer recommendations, if applicable, should be integrated into its procedures.

While there have been many scientific studies conducted on ECDs, ensure that agency training and policy incorporate the most current peer-reviewed, human studies. These studies are considered more relevant and reliable in the scientific community than those studies that used the animal model. For additional information about these studies and ECD updates, please visit www.ECDLaw.info.

Examples and Their Outcomes

The officers involved in the first example (prisoner remained in the prone position after being handcuffed) were being investigated by the agency for a violation of training and policy, and were about to appear before a disciplinary board. Shortly before their appearance, a captain from that agency attended a national conference on sudden, in-custody death and learned the latest scientific data involving a person lying prone, and that there was no scientific proof that permitting a prisoner to remain in the prone position would lead to asphyxia. To the captain's credit, he returned to his agency and argued for a policy change based upon the science. The policy was changed, resulting in all charges against the officers being dropped, thus mitigating the underlying root cause of the genuine problem.

In the second example, the policy of limiting ECD deployment to less than or equal to three was argued at trial, but the force used was determined to be objectively reasonable. The cause of the person's death was related to illicit drug intoxication and not to the ECD.

Protect Most Important Assets

While both of these examples had seemingly positive outcomes, it cost each

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of these governmental entities considerable time, money, energy, and personal anguish to conduct these investigations and, in one case, go through the tribulations of trial. The cost of employer/employee relations is hard to quantify, and no one may ever know the "real (total) cost" of these events in human terms. There are other cases in which the outcomes have not been as positive, with the governmental entities and their officers having been found to have used unreasonable force based upon policy and the facts of the event. In other cases, entities have settled litigation out of court for significant sums of money. Worse is when an officer pleads no contest to a felony in a criminal prosecution rather than face the uncertainties of a trial.

Agency policy that is authored in a vacuum can be a root cause of one or more risk management issues. To minimize municipal, administrator, trainer,

and officer exposure to unnecessary liability, identify one or more past, current, or future risk management problem and then, using the risk management template, proceed through the various steps so a reasonable risk analysis can be conducted. Compare the relevant high-risk policy to current agency training on that subject and to related agency subjects (i.e., compare handcuff training to other restraint training), to other agency policies that might affect the specific policy under review (i.e., compare the prisoner transport policy to the restraint policy), to product warnings, and to scientific findings.

Another root cause can be a disconnect between agency counsel and other lawyers. Too often cases are settled, or, if they go to trial, the outcomes are not discussed or reviewed with management. Ask this question: Where can I put my hands on information concerning lawsuits against the governmental entity involving my agency, agency employees, agency

training, etc. in the last three years so that I can learn what was involved and also the outcome? Generally, the answer to this question is unknown, and when the information is located, the information and outcomes are usually surprising.

The goal is to rewrite the prior formula so that it can be expressed as:

$$T + WP + PW + S = EH$$

Where:

T = training (past or present)

WP = written policy of the agency

PW = product warnings

S = scientific findings

EH = event harmony

While avoiding litigation is always an important goal, protecting the agency's most important asset—people—is justification to perform a risk analysis on high-risk topics. Remember: The more arrows that can be removed from the plaintiff's quiver, the less ammunition there is to shoot. ■