USE OF FORCE AND RESTRAINT POLICY
Annex 1 – Medical warnings on the use of force and restraint

INTRODUCTION

The Australian Institute of Criminology (AIC) has identified that the majority of police deaths in custody occur during the process of detaining. During this time persons are subject to some form of control and restraint tactics. The tactics, physiological and psychological stressors present in these circumstances are comparable to those used by custodial officers during control and restraint situations.

Significantly, persons who have been affected by drugs, and/or are suffering from a mental illness are over-represented in this category. It is due to this alarming statistic that custodial officers must be particularly vigilant due to the prevalence of these risk factors throughout the correctional centre population.

Individuals who die inexplicably during the process of control and restraint display three common characteristics:

- Irrational Behaviour
- Abnormally High Pain Tolerance
- Incredible Strength

There has been, and still is, significant scientific debate in relation to this topic. The specific cause of death in these cases is still debated by medical and coronial authorities. Law enforcement agencies and medical establishments' worldwide, however, support that:

a) Individuals have been dying in the process of control and restraint; and
b) It is possible that *positional asphyxia* contributes to the unexpected deaths of people in states of *acute behavioural disturbance*.

<u>This cannot be ignored</u>.

So what do these terms mean? And what implications do they have on correctional practices?

This ACTCS Situational Response Training:

1. Explains the terms
2. Outlines options and tactics that can be used by custodial officers to manage subjects exhibiting acute behavioural disturbance and use restraint techniques that assist in preventing positional asphyxia.

POSITIONAL ASPHYXIA (PA)

There is a link between restraint positions and the sudden, unexpected death of subjects in custody. The most widely accepted term used to describe the phenomenon is Positional Asphyxia (PA).

Because PA is associated with the action of respiration, it is important to understand the physiology of respiration (how effective breathing takes place). Effective respiration is dependent on three critical elements:

1. An open and "patent" airway which allows air to travel between the lungs & the atmosphere;
2. A sufficient gas exchange between the lung tissue and blood vessels (reduced if cardio-vascular disease is present); and
3. A functional respiratory muscular pump (diaphragm & intercostal muscles) i.e. the chest needs to able to expand and contract in a "bellows" action to allow airflow to occur.

Positional Asphyxia occurs in a situation where a subject is placed in a position where the free action (bellows action) of the diaphragm and intercostal muscles is compromised, thereby causing hypoxia, disturbed heart rhythm and potentially, death. **Simply put – the subject's body position obstructs their breathing that ultimately may lead to suffocation then death.**

CONTRIBUTING FACTORS

As with all use of force decisions, officers need to apply the Situational Use of Force Model to ensure their actions are justified, authorised, tactically sound and adhere to agency policy and procedure. To minimise the risk of PA, officers need to consider a number of other important factors commonly accepted as contributing to this phenomenon:

- **Psychosis -** psychosis can be caused by mental illness, ingestion of drugs, or a combination of the two. Illicit drugs such as methamphetamine, cocaine, PCP, and LSD can cause delusional behaviour and subsequent violent muscular activity. Commonly such subjects are impervious to pain and possess incredible strength thereby requiring several officers to restrain them. Subjects displaying psychosis can go into oxygen debt very quickly. When restraint positions prevent recovery from such an oxygen deficit, heart rhythm disturbances can occur resulting in death.

- **Obesity -** subjects with large protruding stomachs, or 'beer bellies' are at risk from PA as the contents of the abdomen can be forced up within the abdominal chest cavity when the subject is in the prone position. This places pressure on the diaphragm thereby restricting respiration.

- **Diaphragm Muscle Fatigue -** this may occur after an intense period of physical activity i.e. a violent struggle. Such subjects may experience a lack of oxygen to working muscles and body tissues in general, commonly referred to as 'hypoxia'. Subjects may not present any clear symptoms of hypoxia to officers and simply stop breathing whilst being restrained.

- **Cardio Vascular Disease -** reduces lung capacity and blood flow, which restricts the body's ability to exchange gases between lungs and vessels.

- **Multiple officers -** where several officers are required to hold a subject down in the prone position, pressure can be placed on the person's rib cage restricting respiration. Officers need to be aware that the more officers involved in the restraint process, the higher the likelihood that the person will not be able to breathe sufficiently.

- **Cultural -** due to high levels of alcoholism within some indigenous groups, children may possess heart defects and other health issues as a result of developing as a foetus in the womb of an alcoholic mother. Such persons can inexplicably die when involved in foot chases/violent encounters, particularly when under the influence of drugs.

- **Chroming -** inhaling intoxicants such as spray paint and petrol can have adverse effects on an individual's respiration and heart rate. Vision and balance can also be severely impaired. Cognitive processes such as deductive reasoning and speech may also be affected, rendering the subject unable to distinguish between hallucinations and reality, nor interpret any verbal directions.

STAGES LEADING TO POSITIONAL ASPHYXIA

The sequence of events that lead to a PA-related death can be separated into three common stages. It is important that officers have an understanding of these and be able to recognise risk factors and behaviours that may indicate a potential PA situation. This will enable officers to choose tactical options to reduce the potential for PA.

1. **The Incident**
   Typically, a subject is observed displaying irrational and/or delusional episodes accompanied by aggressively violent behaviour. Drug abuse and/or a mental illness are the most likely cause of the subject's behaviour. The subject may have worked themselves up to a state of *acute behavioural disturbance*. Such physical exertion is already heavily taxing the subject's energy and oxygen supply that in turn is contributing to a state of exhaustion (a situation further complicated if they are obese). As this behaviour is perceived as threatening, officers respond.

2. **Officer Intervention**
   In responding to the incident, officers recognise the need for restraint and a struggle begins. Often, the subject is outnumbered and expends considerable energy resisting the responding officers. In an attempt to further restrain and handcuff the subject, officers ground stabilise the subject in the prone position. More officers may be summonsed to achieve this. Experiencing breathing difficulty and pain the subject may struggle harder to get relief.

3. **Exhaustion**
   Due to continued psychosis, panic, or desperation the subject continues to struggle in an attempt to breathe. Responding officers may perceive this as a continued threat and apply even more force to restrain the subject. The subject, totally restrained in the prone position, is unable to move and expends what energy they have left trying to inflate their chest in an

attempt to breath. It is at this point that the subject may become lethally exhausted and die. Even with immediate first aid, the subject is rarely able to be resuscitated.

ACUTE BEHAVIOURAL DISTURBANCE

Acute behavioural disturbance describes the violent and agitated behaviour of subjects under the influence of such drugs or suffering from a mental illness prone to hallucinations and paranoia. Such individuals have been involved in violent encounters with those applying restraint and have died in the process.

Acute behavioural disturbance: a state of extreme mental and physiological excitement characterised by exceptional agitation and hyperactivity, overheating, excessive tearing of the eyes, hostility, superhuman strength, aggression, acute paranoia and endurance without apparent fatigue. This condition is often, but not inevitably, associated with substance or stimulant abuse.

Subjects exhibiting acute behavioural disturbance are by far the most likely category of persons to inexplicably die in custody. The crux of the phenomenon is the physiological occurrences and their effect on the health of an individual outlined below:

Increased body temperature - renders the subject vulnerable to cardio-vascular failure, particularly if there is a pre-existing heart condition. Subjects may also be experiencing delusions and hallucinations which may lead to a state of hysteria due to high body-core temperature. Weather conditions of high temperature and humidity can also contribute to this state. Subjects may remove clothing or strip completely naked in an attempt to cool down. Lethargy and loss of consciousness may eventually occur. Prolonged high body temperature can also cause brain damage.

Dopamine saturation - particularly prevalent in cocaine abuse. The subject's brain is soaked with large amounts of dopamine that causes a euphoric effect which most importantly to officers, means the subject is far less susceptible to pain. A subject experiencing high pain tolerance may not feel injured or exhausted once restrained. The level of exertion however may have severely depleted oxygen levels and placed great strain on the cardio-vascular system.

Adrenaline dump - an adrenaline dump has a two-fold effect. Firstly, adrenaline enables increased muscle activity (fight or flight). The increased blood flow and respiration required to facilitate this effect places considerable stress on the cardio-vascular system rendering the subject vulnerable to heart failure. Secondly, an adrenaline dump can induce incredible strength, which is why several officers are often required to restrain offenders. This situation is further exasperated by high pain tolerance.

Hallucinations and paranoid delusional behaviour - subject may be reacting violently to a psychotic world of hallucinations. Whilst boosted-up on adrenaline and with an inability to feel pain, the subject may have inflicted considerable trauma on themselves prior to officer arrival, which may not present itself physically (e.g. internal bleeding). Combined with an extremely elevated heart rate, high body temperature, and possible exhaustion, the subject's health may already be failing prior to officer intervention.

High blood potassium content - violent muscular activity resulting in an increase in potassium in the subject's blood stream can induce an irregular heartbeat and ultimately heart failure in some individuals.

Officers need to be mindful that acute behavioural disturbance subjects may be experiencing ALL of these health factors and can die during the episode regardless of officer intervention. Such subjects may also be suffering from secondary health problems (as a result of drug use) such as high blood pressure, heart disease, liver damage, and lung degeneration, which further exasperate their vulnerability to dying whilst being restrained.

POSITIONAL ASPHYXIA – SIGNS AND SYMPTOMS

As previously stated ACT Corrective Services acknowledges the use of force is a necessary option when managing non-compliant and violent people within a correctional environment. The territory recognises this by providing legislation *(Corrections Management Act 2007)* authorising the use of force – both lethal and reasonable. There is always a risk of injury in incidents where force is used. By recognising the fundamental risk factors of Positional Asphyxia, correctional officers can apply preventative measures during such incidents to reduce the occurrence of PA.

During the control and restraint process, officers should be aware of the following signs and symptoms:

- Gurgling and/or gasping sounds
- Cyanosis (lips and face turns blue due to lack of oxygen and possibly lapsing into shock)
- Subject saying that they cannot breathe
- Panic - prolonged resistance
- Sudden tranquillity following a violent struggle
- Profuse sweating accompanied with high body temperature

Officers should also be aware that it is practically impossible for those applying restraint to tell the difference between a subject struggling to "escape restraint", and a subject desperately struggling to breathe.

Remember, some subjects may have taxed their body (by a combination of health and drug use factors) to the point of death prior to officer intervention.

Offenders should never be left in the prone position without direct observations being maintained

DEALING WITH ACUTE BEHAVIOURAL DISTURBANCE AND POSITIONAL ASPHYXIA

In any incident officers should use the Situational Use of Force Model as a decision making guide and adhere to the eight Operational Safety Principles of:

1. Safety First
2. Risk Assessment
3. Take Charge
5. Contain and Isolate
6. Avoid Force
7. Minimise Force

4. Planned Response
8. Resources

Note: This model is not restrictive – Correctional Officers can escalate or de-escalate control options as needed. All Use of Force must be proportionate to the immediate risk to the detainee or to anyone else.

ACTIONS THAT MAY ASSIST IN THE MANAGEMENT OF ACUTE BEHAVIOURAL DISTURBANCE

6. **Prompt medical assessment**
   As soon as the subject is secured:
   - Medical staff should conduct a thorough assessment for injuries that may have been self-inflicted or sustained during the struggle.

REMEMBER: Officers should never compromise their own safety or that of others in an attempt to avoid physically restraining an individual if this is the appropriate management option.

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USE OF FORCE AND RESTRAINT POLICY
Annex 2 – Approved instruments of restraint in ACT correctional centres

[redacted]

NOTE: This annex must not be amended without the express approval of the Commissioner.

A. The content of reports must be factual, accurate, objective and complete. You must always include:

- WHO – detainee, witness, victim - use full names and PID numbers
- WHAT – detail the incident, including the lead-up
- WHEN – date and times
- WHERE – location
- WHY – why force or restraint was required
- HOW – detail the actions of the detainee and your actions, including force or restraint.

B. When completing a report, your job is to clearly convey information. Your report must be as fulsome and comprehensive as possible. The report should clearly articulate why force was used and how force was used. A sentence demonstrating this would look similar to the following:
    - "The detainee had a clenched fist with his left hand and he raised to it strike at me so I took hold of his left wrist."

C. Reports must be written in 'active' not 'passive' voice, for example:
    - ACTIVE – Detainee Sam Citizen used a clenched fist to punch officer John Citizen on the nose. ☑
    - PASSIVE – Officer John Citizen was punched in the nose by detainee Sam Citizen with a clenched fist. ☒

    - ACTIVE – Detainee Sam Citizen kicked detainee James Citizen on the right side of his head three times. ☑
    - PASSIVE – Detainee James Citizen was kicked three times in the head by detainee Sam Citizen. ☒

D. Proper grammar, spelling, and punctuation must be used. Do not use legal, technical, slang or jargon words unless in quotation marks (see below).

E. Only use quotation marks when you are directly quoting the words of a detainee or staff member. All other statements are indirect quotations in your own words about what you were told.
    - Example (direct quotation): When describing the incident, detainee Sam Citizen told me "I hit him only once."
    - Example (indirect quotation): When describing the incident, detainee Sam Citizen told me he had punched him only once.

F. Remember that your report is only reflective of your involvement in an incident.

G. Prior to submitting your report, you must read through it and make sure that you have included as much detail as possible about what occurred.

ACTCS has adopted an overarching philosophy to assist in the management of incidents with non-compliant and violent persons.

The successful management of incidents will be judged by the extent to which the use of force is avoided or minimised.

Underpinning this philosophy are eight Operational Safety Principles.

Safety First – The safety of ACT Corrective Services personnel, the community and offenders must be the primary focus.

Risk Assessment – A risk assessment is to be applied to all incidents and operations; planned or unplanned.

Take Charge – Effective command and control must be exercised regardless of seniority or rank.

Planned Response – Every opportunity to convert an unplanned response into a planned response is to be explored.

Contain and Isolate - Where practical every incident should be contained and isolated.

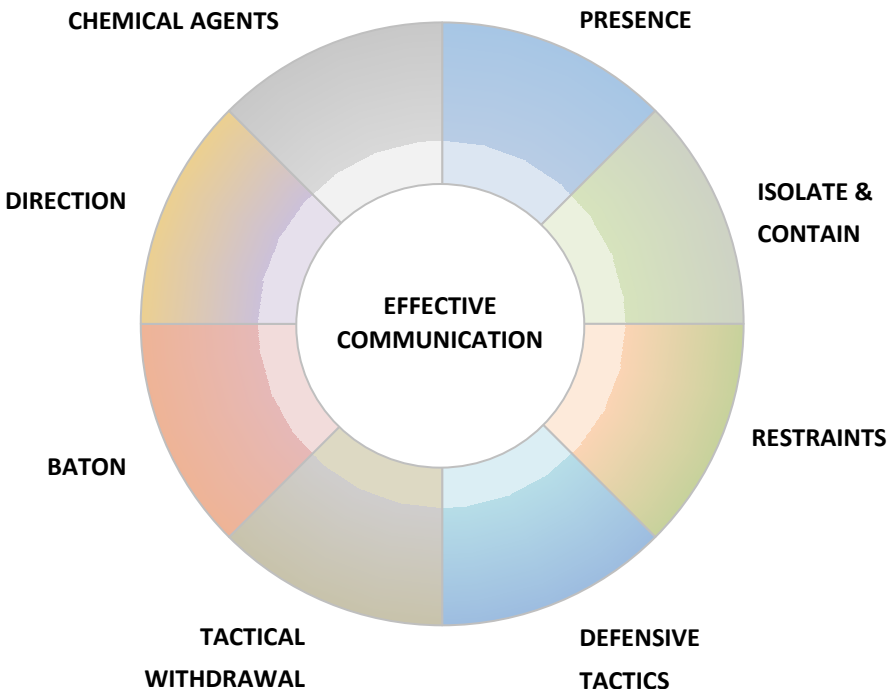
Avoid Force – The use of force should be avoided.

Minimum Force – Where the use of force cannot be avoided, only the minimum force reasonably necessary should be used.

Resources – To achieve the safety first principle; additional resources, more detailed planning and more time to manage an incident may be required.

SITUATIONAL USE OF FORCE MODEL

ACT Corrective Services has adopted the 'Situational Use of Force Model' as a guide to assist officers when dealing with non-compliant and violent subjects. The 'Situational Use of Force Model' visually represents a correctional officer surrounded by the 'use of force' control options available to officers. This model assists the officer to select the most appropriate options to resolve an incident. The 'Situational Use of Force Model' is not restrictive. Officers may select other 'use of force' options to escalate or de-escalate the 'use of force' if necessary.



EFFECTIVE COMMUNICATION

Central to this model is effective communication. Communication is a dynamic process and is probably the most important tactical option available to correctional officers. The aim of operational communication is to assist officers to manage incidents **without the need to use force** or to minimise the force being used. This is achieved by defusing volatile situations and turning non-compliant and violent subjects into compliant subjects through effective communication.

PRESENCE

Presence is an exercise of force because the mere fact that a Correctional Officer is present influences behaviour. Presence in a correctional context is an intricate and complex mix of knowledge, skills, tactics, and procedures combined with an understanding of human behaviour.

The key components of the Presence Option are:

- Identification of who you are
- Communication (verbal and non-verbal)
- Risk Assessment
- Safety Concepts (positions of safety, stance, safety distances, vision, movement and teamwork).

ISOLATE & CONTAIN

Things to consider when facing an emergency situation are:

- Danger to community, subjects, Corrective Services staff and/or environment.
- Significant threat level.
- Situation has opportunity to escalate.
- Prevent situation from expanding to include others.

RESTRAINTS

Using departmental approved restraints by trained and authorised officers.

DEFENSIVE TACTICS

Defensive tactics are skills used by Correctional Officers when control of a situation cannot be achieved by communication skills or mere presence. Effective communication is especially important when using these tactics – you are using tactics to gain compliance, you need to let the subject know what you want them to do.

TACTICAL WITHDRAWAL

A tactical withdrawal should be considered when unable to physically respond effectively, logistically or where personal safety is compromised. Officers should tactically withdraw when:

- current resources are insufficient for the circumstances.
- to prevent injury to staff and offender.
- to gather further intelligence.
- reassessing the situation.
- developing a plan.
- your actions might jeopardise others' lives. Don't act unless lives are in immediate, obvious danger.
- a subject needs help to back down from an aggressive stand they have taken, or are confused or uncertain of what next step to take.

How to withdraw **–** Don't run as a panic reaction, but a positive action. Go towards a place of safety not just away from danger. Once started, don't hesitate or stop until free and clear.

BATON

The use of departmental approved batons and shields by trained and authorised officers.

DIRECTION

Giving formal direction to an offender to achieve an outcome.

Key Points: Situational Use of Force Model

- The model is intended to be used as a decision making guide for officers when dealing with 'Use of Force' incidents.
- It visually represents an officer surrounded by the use of force options currently available to him/her.
- The model requires the officer to select the most appropriate option for the resolution of the incident.
- It is not restrictive. The officer may select other force options when and if necessary.