ONE BREATH: THE IMPORTANCE OF RECOGNIZING AGONAL & OTHER BREATHING PROBLEMS
USER-LEVEL STUDY GUIDE
Version 1.0e

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Institute for the Prevention of In-Custody Deaths, Inc.

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WELCOME and INTRODUCTION

Welcome to the Institute for the Prevention of In-Custody Deaths, Inc. (IPICD) Online Training Center and its tuition-free One Breath: The Importance of Recognizing Agonal & Other Breathing Problems User-level online training program. The IPICD staff members are convinced this subject is crucial for all law enforcement officers (LEO) to know, so a decision was made to offer this online program tuition-free. To assist you in successfully completing the program, we suggest printing the One Breath: The Importance of Recognizing Agonal & Other Breathing Problems User-Level Study Guide.

We know you will find this online training program not only beneficial and practical, but also valuable for minimizing or avoiding a “failure-to-train” and/or “negligent training” lawsuit that may be filed against your employer about its alleged failure to specifically train you about recognizing agonal breathing and other breathing difficulties. Governmental entities have been sued by family members of a decedent who had died claiming the LEOs employer had failed to provide him or her with training about agonal breathing, among other possible claims. In short, the plaintiff alleged that had the LEO been trained by his or her employer to recognize breathing difficulties, specifically agonal breathing, and then performed cardiopulmonary resuscitation (CPR) or summoned emergency medical services their loved one would have survived. Your successful completion of this online program should remove that “arrow” from the plaintiff’s quiver of “failure-to-train” and/or negligent training claims. Make sure to provide your employer with proof of successful completion of this IPICD online program. After passing the online assessment, you will be able to print a customized certificate.

Knowing about and understanding human breathing difficulties including agonal breathing is necessary but not sufficient. You will also need to obtain and maintain certification in both CPR and in how to use an Automatic External Defibrillator (AED). If your CPR card has expired, please get it renewed. This online program will not teach you how to perform CPR or how to use an AED.

Knowing CPR is important for your community. In 2013 there were an estimated 395,000 out-of-hospital cardiac arrests that occurred in the United States (Institute of Medicine, 2015, p. 21). This 2015 report revealed a wide variation of cardiac arrest survival rates depending upon several variables, including community location, recognition of cardiac arrest, early access to 9-1-1, CPR treatment, early defibrillation, early access to advanced cardiac life support treatment, and early post-resuscitative care (pp. 35-36). Being able to treat a cardiac arrest person with CPR is important, just as having easy and immediate access to an AED that is kept in a patrol vehicle, on a wall, etc.

Training and educating criminal justice professionals and other first responders about human breathing difficulties and specifically about agonal breathing are considered, whether it is pre-service or in-service, as career and technical education (CTE). This online training program meets the criteria for CTE. The program materials also comply with the “Americans with Disabilities Act” requirements. There are also a few “required items” that you will find beneficial.
The following “Required Items” will help to make your online experience more pleasurable and successful:

- Computer with speakers (all slides have optional audio narration that provides additional information; there are also required videos to watch that have sound),
- Computer with dependable Internet connection (high speed recommended for best results),
- Knowledge on how to navigate the Internet,
- Mouse (unless using touch screen),
- Keyboard (unless using touch screen),
- Printer (optional),
- IPICD One Breath: The Importance of Recognizing Agonal & Other Breathing Problems User-Level Study Guide,
- Comfortable chair,
- Comfortable writing surface for note taking,
- Writing instrument, and
- Highlighter for marking passages in the Study Guide.

Taking periodic breaks should also make the online program more enjoyable. Remember to rest your eyes, and take a break from staring at a computer screen. The online portion of the program takes approximately 90 minutes to complete (includes taking of assessment).

If you have a question, please send an email to the IPICD: staff@ipicd.com. An IPICD-qualified instructor or appropriate professional will respond to your questions via email.

IPICD staff members are confident that after successfully completing this tuition-free online program you will see how simple it is to use the IPICD Online Training Center and how much fun it is to learn. You will want to enroll in future online programs, or in an IPICD traditional classroom training program located near you.

Again, welcome to this IPICD online program. Have a wonderful and positive educational experience.

Best wishes,
FOR: Institute for the Prevention of In-custody Deaths, Inc.

John & Brian

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Program Consultant
PROGRAM GOALS & PERFORMANCE OBJECTIVES

PROGRAM GOALS:

- To define agonal breathing.
- To define normal breathing.
- To define abnormal breathing.
- To define cardiac arrest.
- To define heart attack.
- To define ventilation.
- To define respiration.
- To define inhalation.
- To define exhalation.
- To define ventricular fibrillation.
- To define and explain the human “gas exchange” process.
- To define and explain “normal” and “abnormal” breathing.
- To define and explain the importance of knowing about agonal breathing.
- To discuss select high-profile arrest-related deaths across the United States.
- To discuss public distrust of governmental entities and what is being demanded.
- To discuss the importance of performing cardiopulmonary resuscitation (CPR) on individuals who are not breathing normally and are unconscious.
- To discuss the importance of training 9-1-1 Call-Takers, Dispatchers, and other first responders about agonal breathing.
- To explain why “talking” does not mean the person is “breathing.”
- To identify the many labels given to agonal breathing.
- To identify behavioral cues and symptoms associated with agonal breathing.
- To identify behavioral cues and symptoms associated with breathing difficulties.
- To identify and discuss “Best Practices” for assisting people experiencing breathing difficulties.
- To demonstrate agonal breathing through video.
- To demonstrate the gas exchange process through video.

PROGRAM PERFORMANCE OBJECTIVES:

- Given an IPICD Version 1.0e *One Breath: The Importance of Recognizing Agonal & Other Breathing Problems User-Level Study Guide*, online instruction, and a multiple choice question, the learner will be able to correctly identify why talking is not breathing with a minimum performance level of 100%.
- Given an IPICD Version 1.0e *One Breath: The Importance of Recognizing Agonal & Other Breathing Problems User-Level Study Guide*, online instruction, and a multiple choice question, the learner will be able to correctly identify 2 demands of governmental entities being made by the American public with a minimum performance level of 100%.
• Given an IPICD Version 1.0e One Breath: The Importance of Recognizing Agonal & Other Breathing Problems User-Level Study Guide, online instruction, and a multiple choice question, the learner will be able to correctly identify 4 causes of “air hunger” with a minimum performance level of 100%.

• Given an IPICD Version 1.0e One Breath: The Importance of Recognizing Agonal & Other Breathing Problems User-Level Study Guide, online instruction, and a multiple choice question, the learner will be able to define the term “breathing” with a minimum performance level of 100%.

• Given an IPICD Version 1.0e One Breath: The Importance of Recognizing Agonal & Other Breathing Problems User-Level Study Guide, online instruction, and a multiple choice question, the learner will be able to define the term “normal breathing” with a minimum performance level of 100%.

• Given an IPICD Version 1.0e One Breath: The Importance of Recognizing Agonal & Other Breathing Problems User-Level Study Guide, online instruction, and a multiple choice question, the learner will be able to define the term “ventilation” with a minimum performance level of 100%.

• Given an IPICD Version 1.0e One Breath: The Importance of Recognizing Agonal & Other Breathing Problems User-Level Study Guide, online instruction, and a multiple choice question, the learner will be able to define the term “inhalation” with a minimum performance level of 100%.

• Given an IPICD Version 1.0e One Breath: The Importance of Recognizing Agonal & Other Breathing Problems User-Level Study Guide, online instruction, and a multiple choice question, the learner will be able to define the term “exhalation” with a minimum performance level of 100%.

• Given an IPICD Version 1.0e One Breath: The Importance of Recognizing Agonal & Other Breathing Problems User-Level Study Guide, online instruction, and a multiple choice question, the learner will be able to correctly identify the two gases associated with respiration with a minimum performance level of 100%.

• Given an IPICD Version 1.0e One Breath: The Importance of Recognizing Agonal & Other Breathing Problems User-Level Study Guide, online instruction, and a multiple choice question, the learner will be able to correctly identify the rate of breaths associated with adult “normal breathing” with a minimum performance level of 100%.

• Given an IPICD Version 1.0e One Breath: The Importance of Recognizing Agonal & Other Breathing Problems User-Level Study Guide, online instruction, and a multiple choice question, the learner will be able to correctly identify 3 potential causes of “abnormal breathing” with a minimum performance level of 100%.

• Given an IPICD Version 1.0e One Breath: The Importance of Recognizing Agonal & Other Breathing Problems User-Level Study Guide, online instruction, and a multiple choice question, the learner will be able to correctly identify when agonal breathing may occur in an individual with a minimum performance level of 100%.

• Given an IPICD Version 1.0e One Breath: The Importance of Recognizing Agonal & Other Breathing Problems User-Level Study Guide, online instruction, and a multiple choice question, the learner will be able to correctly identify at least 5 labels given to agonal breathing with a minimum performance level of 100%.
• Given an IPICD Version 1.0e One Breath: The Importance of Recognizing Agonal & Other Breathing Problems User-Level Study Guide, online instruction, and a multiple choice question, the learner will be able to correctly identify the approximate percentage agonal breathing is associated with cardiac arrest with a minimum performance level of 100%.

• Given an IPICD Version 1.0e One Breath: The Importance of Recognizing Agonal & Other Breathing Problems User-Level Study Guide, online instruction, and a multiple choice question, the learner will be able to correctly identify 2 important questions 9-1-1 Call- Takers should ask a caller to help identify agonal breathing with a minimum performance level of 100%.

• Given an IPICD Version 1.0e One Breath: The Importance of Recognizing Agonal & Other Breathing Problems User-Level Study Guide, online instruction, and a multiple choice question, the learner will be able to define the term “cardiac arrest” with a minimum performance level of 100%.

• Given an IPICD Version 1.0e One Breath: The Importance of Recognizing Agonal & Other Breathing Problems User-Level Study Guide, online instruction, and a multiple choice question, the learner will be able to define “heart attack” with a minimum performance level of 100%.

• Given an IPICD Version 1.0e One Breath: The Importance of Recognizing Agonal & Other Breathing Problems User-Level Study Guide, online instruction, and a multiple choice question, the learner will be able to correctly identify 2 facts about agonal breathing with a minimum performance level of 100%.

• Given an IPICD Version 1.0e One Breath: The Importance of Recognizing Agonal & Other Breathing Problems User-Level Study Guide, online instruction, and a multiple choice question, the learner will be able to correctly identify what (s)he should not attempt with the person (unless qualified) with a minimum performance level of 100%.

• Given an IPICD Version 1.0e One Breath: The Importance of Recognizing Agonal & Other Breathing Problems User-Level Study Guide, online instruction, and a multiple choice question, the learner will be able to correctly identify 4 actions a law enforcement officer must take when assisting an unconscious person with a minimum performance level of 100%.
DESIGN of the STUDY GUIDE

- The IPICD Version 1.0e One Breath: The Importance of Recognizing Agonal & Other Breathing Problems User-Level Study Guide is designed as a full-sentence, directed outline and resource document.

- There are many references cited throughout the paragraphs. The citations are in two formats: in-text and end-of-text. In-text citations are located within the sentence (e.g., Berman (2012)), and contain the author(s) followed by the date of the publication. End-of-text citations are located at the end of a sentence and contain the author’s name followed by the date of publication (e.g., The sky is blue (Smith, 2009)).

- Regardless of the citation format, the text, article, treatise, etc. are located on the “Reference” page of the Study Guide. If someone wants to obtain the name of the document so (s)he can read it, the “References” page lists the works cited within the Study Guide.

- Each lesson is divided into 3 sections: Breadth, Depth, and Application.

- The Breadth section discusses the theoretical, scientific, medical, and/or conceptual bases of the knowledge area, and examines their differences and similarities.

- The Depth section interprets the issues or problems facing law enforcement officers (LEOs) and others who are impacted by someone experiencing breathing difficulties.

- The Application section discusses how and/or what evidence- or experientially-based theories, guidelines, protocols, etc. can be applied to breathing difficulty situations.

NOTES:
LESSON 1: INTRODUCTION

BREADTH:

1.1 Public mistrust of law enforcement has grown across the United States and globally.

1.2 In uncommon situations, LEOs have encouraged public mistrust. Examples include, but are not limited to when a blank piece of paper was used as a search warrant, when illegal drugs were “planted” inside a car or on a person, and when negative comments were made about a person in distress.

1.3 During the last several years, several high-profile LEO-involved events, including where suspects have said they could not breathe, were videotaped by citizens using cellular telephones and then uploaded to social media.

1.4 These events published on both the social media and the mainstream media have only fueled, deepened, and galvanized the public’s mistrust of law enforcement officers.

1.5 “The public is demanding accountability and transparency from governmental entities, including law enforcement” (Peters, Wilhite, & LaRochelle, 2015).

1.6 Many of these high-profile and tragic arrest-related death events involved individuals who said they could not breathe.

1.7 While law enforcement officers generally receive good training on how to contain, capture, control, and restrain people, often times little, if any, training is given to them about post-restraint issues, such as how to identify breathing difficulties.

1.8 Compounding this lack of training is the dangerous misunderstandings officers may have about “breathing.”

1.9 Myth: One or two breaths means the person is breathing.

1.10 Myth: If a person is talking, (s)he is breathing.

DEPTH

1.11 LEOs often encounter people who are in an altered mental state.

1.12 In some instances, inadequate ventilation (low oxygen or high carbon dioxide levels) may have caused the individual’s altered mental state.

1.13 Anxiety, drugs, asthma, running from LEOs, and/or struggling with LEOs can increase a person’s demand for oxygen.
Regardless of the cause(s) of breathing difficulties, many times these individuals will tell LEOs and by-standers they are experiencing breathing problems.

For example, Mr. Jorge Azucena (Mr. Azucena) was arrested by Los Angeles Police Department (LAPD) officers after he ran a red light (Associated Press, 8/24/2014, p. A22).

After he was handcuffed, Mr. Azucena told officers that he could not breathe, but they did not take him seriously (Associated Press, 8/24/2014, p. A22).

A sergeant who was at the scene told Mr. Azucena, “You can talk, so you can breathe” (Associated Press, 8/24/2014, A22).

Another example is Mr. Rodney Brown (Mr. Brown) who reportedly told police officers through a wheezing voice, “I can’t breathe” (Dissell, 2014).

After Mr. Brown had told officers he could not breathe, Officer Erick Melendez was heard on his police radio saying, “So? Who gives a f—k” (Dissell, 2014).

The 2014 high-profile event that went viral involved Mr. Eric Garner (Mr. Garner), 43, who was arrested by officers of the New York City Police Department (NYPD) on July 17th for allegedly selling untaxed cigarettes (Queally & Semuels, 2014).

During the arrest, officers struggled with Mr. Garner with one officer placing his arm across Mr. Garner’s throat area (Queally & Semuels, 2014).

After wrestling the approximately 400-pound Mr. Garner to the ground, Mr. Garner repeatedly said, “I can’t breathe” (Queally & Semuels, 2014), before he died.

The officers’ struggle with Mr. Garner was captured by a civilian, Mr. Ramsey Orta (Mr. Orta), using his cellular telephone (Sanburn, 2014).

In April 2015 a Tulsa, Oklahoma reserve deputy shot Mr. Eric Harris (Mr. Harris), 44, after confusing his handgun with a TASER® as officers were struggling with Mr. Harris on the ground after he ran away from them (Holley, 2015).

Mr. Harris can be heard telling the officers on video that he had been shot and that he was losing his breath (Holley, 2015).

One officer responded saying, “F..k your breath” (Holley, 2015).

APPLICATION

It is important for LEOs to recognize people who are having breathing difficulties.
1.28 LEOs must also consider the person may be trying to “trick” them by saying “I can’t breathe” to delay or obstruct LEO intervention.

1.29 It is clear from the previously reported events and similar arrest-related death events when a suspect said he was having breathing difficulties officers dismissed this concern and treated the person as being able to breathe. Governmental entities must train and educate officers about respiration (oxygenation), ventilation, and how to recognize breathing difficulties.

1.30 Officers must also learn about agonal breathing, which is often associated with cardiac arrest and occurs before death, including what they might do to assist a person with breathing difficulties.

1.31 Officers must also learn there are many potential causes of “air hunger” including, but not limited to: asthma, trauma to the chest, trauma to a major airway, and chronic obstructive pulmonary disease (COPD), etc. among others.

1.32 Regardless of the cause(s) of “air hunger,” this is a medical emergency and the people in these situations need to be treated by medical professionals.

1.33 LEOs will also encounter people who are in an agitated state and/or who may have altered levels of consciousness.

1.34 Of all the organ systems of the body, the three most important are respiratory, cardiovascular, and neurological. While there are many other pathways to altered levels of consciousness, one should assume a derangement within one of these three systems. Get medical assistance right away.

1.35 It is important that LEOs are trained how to recognize a person in medical distress, which will, at some point in time, change the person’s status from, say, “suspect” to “patient”.

1.36 Officers must also act professional during these often-tragic and high-profile events.

1.37 As civilians video more law enforcement interactions with the public and more law enforcement officers wear body-worn cameras, behaviors and words of both officers and suspects will be recorded.

1.38 Although video footage has shortcomings (e.g., showing a different angle than what the officer sees), when coupled with audio recording, it will eliminate officers who try to say, “I did not do that,” but video that captured the event will replace a subjective narration of the event by the involved officer(s) (Peters, Wilhite, & LaRochelle, 2015).
1.39 This pioneering IPICD online training program sets a training standard whereby all LEOs—including other interested parties—can get trained *tuition-free*. It will become difficult for law enforcement administrators to claim that “no training was available on breathing difficulties and agonal breathing,” which prior to this online program may have been used as an affirmative defense.

1.40 Lesson 2 discusses ventilation and respiration.

NOTES:
LESSON 2: UNDERSTANDING VENTILATION and RESPIRATION

BREADTH

2.1 Breathing involves both ventilation and respiration.

2.2 *Ventilation* refers to the moving of air into and out of the lungs (Myers, 2006).
   - The taking in of air is called *inhalation*;
   - The discharge of air into the atmosphere is called *exhalation*. As a person ventilates CO$_2$ out, more O$_2$ is needed by the body. *Inhalation* is moving air into the lungs; *exhalation* is moving air out of the lungs; and,
   - This process brings in more O$_2$ to the body, and exhausts CO$_2$, which is a “waste product” of metabolism. The body needs to rid itself of harmful increased levels of CO$_2$.

2.3 Normally, adults breathe between 12 and 20 breaths per minute (Myers, 2006, p. 5).

2.4 *Respiration* refers to: (1) how oxygen (O$_2$) diffuses from the air into the lungs (Alveoli); and (2) how carbon dioxide (CO$_2$) is then diffused from the blood into the lungs and discharged into the atmosphere (Myers, 2006, p. 3). With each breath, O$_2$ is brought into the lungs, and CO$_2$ is expelled from the lungs.

2.5 The process of oxygenating the blood and releasing CO$_2$ into the atmosphere is referred to as “gas exchange.”

2.6 There are two divisions to the human *respiratory system*: upper respiratory tract and the lower respiratory tract (Myers, 2006).

2.7 The *upper respiratory tract* consists of: (1) the nasal and oral cavities; (2) pharynx; (3) larynx; and (4) trachea (Myers, 2006, p. 3). Basically the upper respiratory tract airway structures are in the neck, with the trachea located in the chest.

2.8 The primary function of the *upper respiratory tract* is to filter the incoming air (nose hairs), warm it, and moisten it so the air is suitable for the gas exchange process (Myers, 2006. p. 3).

2.9 The *lower respiratory tract* consists of: (1) main bronchi; and (2) lungs (Myers, 2006, p. 3).

2.10 A falling level of O$_2$ or an increase in CO$_2$ can cause a change in the individual’s mental status.

2.11 Air moves in and out of the lungs due to the pressure changes inside the chest.
2.12 During **inhalation** the diaphragm contracts and moves downward, while the muscles between the ribs (known as the Intercostal muscles) contract and cause the angle of the ribs to shift upward. As a result, negative pressure inside the chest cavity causes air to flow inside the lungs. Because muscular work is required to inhale, inhalation is an **active** process.

2.13 **Exhalation**, on the other hand, is ordinarily a **passive** process: the Intercostal muscles and diaphragm simply relax. Because of the natural elasticity of the lungs, air is forced out, just like air is forced out of balloon when you release its stem. In other words, under normal circumstances, there is no work involved in exhalation. **Exceptions:** People use the muscles of exhalation when they cough, yell, sing, or blow out birthday candles, and during exertion or recovery from exertion. Under other circumstances use of respiratory muscles to exhale should be considered **abnormal**.

2.14 Physicians talk about the use of accessory muscles of respiration: neck and abdominal muscles. If people vigorously contract their neck muscles during inhalation or their abdominal muscles during exhalation, this indicates breathing difficulty or even respiratory distress.

2.15 Slide # 22 (Lesson 2) shows how the chest acts like a bellows.

2.16 **Alveoli** (gas exchange) are thin-walled, balloon-like air sacs located throughout the lungs.

2.17 **Pulmonary capillaries** are the tiny blood vessels that surround the Alveoli. They deliver CO\textsubscript{2} to the Alveoli and O\textsubscript{2} is released from the blood into the Alveoli.

2.18 The **pulmonary arteries** deliver blood to the lungs, and the **pulmonary veins** return the blood to the heart.

2.19 Gas exchange only takes place in the Alveoli, not in the trachea or bronchi.

2.20 The **gas exchange process** involves three important steps: (1) ventilation; (2) perfusion; and (3) diffusion (Myers, 2006, p. 4).

2.21 **Perfusion** (in this context) refers to blood from the pulmonary artery that is pulsing through the pulmonary capillaries. Metaphorically, think of a train with several empty coal cars located under a large hopper filled with coal (oxygen). If the train is moving too fast (heavy breathing), the coal hopper will be drained quickly (taking a lot of oxygen from the lungs). Conversely, if the train is moving slowly (low cardiac output) or not moving at all (cardiac arrest) carbon dioxide accumulates in the blood and tissues and is not exhausted in the lungs.
2.22 Diffusion refers to the process of the movement of Carbon Dioxide (CO₂) and Oxygen (O₂) between the lungs and blood (Myers, 2006). When the concentration of CO₂ is higher, it becomes “waste air” and moves in the opposite direction of O₂ in the alveoli and then is exhaled (Teach PE, 2015). People can experience derangement from ventilation, perfusion, or diffusion because of low O₂ or high CO₂ levels.

2.23 During the third and fourth steps of respiration, Oxygen (O₂) and Carbon Dioxide (CO₂) “diffuse across the alveolar membrane . . . and between the tissue capillaries and cells” (Myers, 2006, p. 5).

2.24 Oxygen (O₂) is considered the “good air.”

2.25 Carbon Dioxide (CO₂) is waste product of metabolism. If CO₂ levels are too high, a person may experience altered consciousness, and/or develop acidosis that could have fatal consequences.

2.26 Please watch the animation video on “gas exchange” to gain a visual understanding of how this process works in the human body.

DEPTH

2.27 Lesson 1 described several situations where law enforcement officers were in contact with individuals who were experiencing breathing problems and died.

2.28 In some cases, individuals experience breathing difficulties after struggling with officers or after fleeing on foot.

2.29 Breathing problems can happen to anyone: civilians, you, and/or your colleagues.

2.30 A non-scientific survey of officers conducted by staff of the Institute for the Prevention of In-custody Deaths, Inc. (IPICD) found that over 90% of the officers surveyed had not received any training about human ventilation and respiration.

APPLICATION

2.31 If a person is talking, it does not mean that (s)he has good gas exchange. Talking is simply the movement of air over the larynx, and has nothing to do with proper gas exchange. Focus upon the content of what the person is saying and how it is being said. If a person can’t say his or her name, uses 1- or 2-word sentences, or what (s)he is saying makes no sense, seems confused, or the content is abnormal in the context of what is happening, this could be an indicator of low O₂ or high CO₂ and the person needs immediate medical attention. The myth of “If (s)he is talking he is breathing” is only that . . . a false belief!
2.32 Many times, the person who says “I can’t breathe” is not properly discharging Carbon Dioxide (CO₂) for his or her body, and is actually “suffocating” from the build-up of CO₂, or from low O₂. His or her gas exchange process is not properly functioning, and (s)he may be suffocating, and needs immediate medical attention.

2.33 When a person is choking on, say, a piece of meat, this is a ventilation issue, even though the perfusion and the diffusion processes can still function as designed.

2.34 Lesson 3 builds upon this lesson and discusses “normal and abnormal breathing.”

NOTES:
LESSON 3: NORMAL and ABNORMAL BREATHING

BREADTH

3.1 Normal breathing includes, but is not limited to: (1) breathing at rest, and (2) breathing at recovery.

3.2 Breathing at rest has a low oxygen demand.

3.3 Recall from Lesson 2 the normal range of breaths per minute for human beings is between 12 and 20 (Myers, 2006, p. 5).

3.4 Normal breathing is also usually quiet and effortless (e.g., sitting in a chair).

3.5 Exercise (e.g., running), exertion (e.g., lifting weights), anxiety, and/or drugs can create an increased demand for more Oxygen (O$_2$), and a demand to eliminate more “waste air” (Carbon Dioxide).

3.6 Rapid and heavy breathing is a normal response following exercise and/or exertion.

3.7 Allowing for good ventilation (inhalation and exhalation) will allow for good respiration and thus recovery.

3.8 There are many factors that can affect ventilation and gas exchange. These include, but are not limited to: pre-existing illness, lung disease, injury, licit or illicit drug abuse, trauma, spinal injuries that limit the use of muscles for ventilation and respiration. Disease (e.g., COPD) airway obstruction, etc. can also cause abnormal breathing in humans.

3.9 A totally separate issue relates to how the person was restrained, and if the restraint process or method contributed to the person’s death. After a person has been placed into restraints, position or re-position him or her to make sure ventilation is not impaired. Provided the person has not suffered a serious injury (e.g., neck or spinal cord injury), if possible, sit the person upright or on the side (recovery or recumbent position) to help minimize a claim of “positional asphyxia.” People have died in the sitting, recumbent, or standing positions. Monitor the person continuously, and if the person has a breathing problem or claims to have a breathing problem, obtain immediate medical assistance.
3.10 Signs and/or symptoms of abnormal breathing include, but are not limited to: (1) rapid breathing (> 20 breaths per minute called tachypnea; hyperventilation); (2) slow breathing (< 12 breaths per minute called bradypnea; hypoventilation); (3) shallow breathing; (4) irregular breathing; (5) noisy breathing; (6) increased work of breathing including exaggerated use of breathing muscles, flaring of nostrils, grunting excessively deep breathing; (7) cyanosis (blue discoloration of the skin); (8) restlessness; and/or (9) anxiety (Myers, 2006, pp. 185-186; Curtis, 2015, personal communication).

DEPTH

3.11 There are several examples of LEOs having struggled with a person who was then placed into restraints and then became non-responsive during transport. In some cases officers reported “believing” the person had gone to sleep because of hearing snoring noises. Snoring noises may also indicate partial airway obstruction.

3.12 If a person’s level of consciousness is deteriorating, it may be an oxygenation issue.

3.13 Sometimes, people who are dying will quietly fade and become non-responsive. Such perceived “compliance” by the suspect may in fact be death.

APPLICATION

3.14 If a person’s breathing is erratic, labored, gasping, or gulping, the person needs to be constantly monitored, and medical assistance requested.

3.15 Similarly, if a person is experiencing abnormal breathing after a reasonable timeframe for recovery, (s)he needs medical attention (e.g., erratic or gasping after a city-block-long foot pursuit).

3.16 Abnormal breathing must be considered by officers as a “medical emergency.”

3.17 Emergency medical service providers must immediately be summoned to the scene.

3.18 **Talking does not equal breathing.** Paramedics recognize that a patient who talks in short or one-word sentences is in medical trouble and needs immediate treatment. Officers need to watch for this situation, too.

3.19 If a person subjectively says “I can’t breathe” or uses similar words, do not dismiss the person’s claim. While a person may say something to make you come closer so (s)he can assault you, remain careful, but do not ignore the person. Also, do not mock or belittle the person. Officers must demonstrate concern and remain professional at all times. Show compassion. Compassion is empathy in action for the good of another person.
3.20 Request medical attention for the person if abnormal breathing is noticed, and/or if the person complains about breathing difficulty.

3.21 If you or the attending officer is not qualified to perform appropriate first aid (e.g., CPR), or if you are unsure what to do until the ambulance arrives, make sure the person is positioned for good ventilation. Talking to the person or touching him or her in a comforting way may also be positive responses that will be captured on video or seen by by-standers.

3.22 **DO NOT** just stand there and do nothing!

3.23 Remember: A person who suddenly becomes “compliant” may in fact be dying. Death may look like compliance.

3.24 Lesson 4 discusses agonal breathing.

**NOTES:**
LESSON 4: AGONAL BREATHING

BREADTH

4.1 One of the worst scenarios to experience is to have a person die during or following the arrest process, or while in-custody and not recognize the person has died or was dying.

4.2 LEO, Dash Cam, and civilian video have shown restrained individuals sitting, lying prone, or lying on their side making grunting sounds or taking “guppy” breaths while LEOs watched them, only to have them die shortly thereafter.

4.3 Many of these videotaped individuals were experiencing and demonstrating agonal (ag-uh-nl) breathing, but to the untrained LEO it looks and sounds like the person continued “breathing.”

4.4 Abnormal breathing in an unconscious person that may appear as irregular and sporadic gasps or gulps for breath is often agonal (ag-uh-nl) breathing.

4.5 Agonal respirations are often heard by those people who are near a person prior to death (Eisenberg, 2006).

4.6 Agonal respirations, or what is commonly called agonal breathing, looks or sounds like: snoring; heavy breathing; labored or exaggerated breathing; gurgling; guttural sounds; groaning; snorting; and/or gasping (Bobrow, Zuercher, Ewy, Clark, Chikani, Donahue, Sanders, Hilwig, Berg, & Kern, 2008; Eisenberg, 2006).

4.7 Agonal breathing can be seen in individuals who have suffered cardiac arrest (Bobrow, Zuercher, Ewy, Clark, Chikani, Donahue, Sanders, Hilwig, Berg, & Kern, 2008; Eisenberg, 2006). There are a multitude of other causes of agonal breathing such as Central Nervous System injury (e.g., brain trauma, high blood pressure).

4.8 Cardiac arrest is when the heart stops beating. IOM (2015) defined cardiac arrest as “a severe malfunction or cessation of the electrical and mechanical activity of the heart” (p. 27). A person who has suffered a cardiac arrest will rapidly become unconscious. Death follows if the heart beat is not restored.

4.9 Cardiac arrest is different than a heart attack. A heart attack occurs when the blood flow is interrupted to part of the heart muscle because of a blockage or a narrowing of arteries that supplies that area of the heart (IOM, 2015, p. 28). Not everyone who has a heart attack will go into cardiac arrest. In fact, few people who have heart attacks will die from it in the short-term; whereas, in cardiac arrest, death follows if the heart beat is not rapidly restored.
4.10 Many people who suffer cardiac arrest are not in hospitals, and many of these individuals will make unusual breathing sounds that can be heard by people standing close to them (Bobrow, Zuercher, Ewy, Clark, Chikani, Donahue, Sanders, Hilwig, Berg, & Kern, 2008). Recall from the “Introduction” in 2013 there were an estimated 395,000 out-of-hospital cardiac arrests that occurred in the United States (Institute of Medicine, 2015, p. 21).

4.11 Agonal breathing is a brainstem reflex, and is an ominous sign that death is imminent.

4.12 In an unconscious person, agonal breathing indicates cardiac arrest until proven otherwise. CPR must be started immediately, and medical assistance requested.

4.13 Scientific research has shown:

- Approximately 40% of individuals suffering cardiac arrest had agonal respirations,
- Approximately 56% of individuals in ventricular fibrillation had agonal respirations,
- Approximately 60% of people surviving cardiac arrest had agonal respirations
- Agonal respirations were associated with survival of the previously-mentioned individuals, (Bobrow, Zuercher, Ewy, Clark, Chikani, Donahue, Sanders, Hilwig, Berg, & Kern, 2008; Eisenberg, 2006; Gazmuri & Kube, 2003; Rea, 2005).

4.14 Agonal breathing starts as vigorous gasping and fades to apnea (absence of breathing) within several minutes.

4.15 Take a moment and watch the agonal breathing demonstration videos.

**DEPTH**

4.16 LEOs are often the first responders that come into contact with individuals who have experienced cardiac arrest or who are in ventricular fibrillation (here the heart quivers and is ineffective at pumping blood, leading to cardiac arrest).

4.17 Because LEOs are often not trained on what agonal breathing sounds like, the officers who are at the scene with the individual may mistakenly believe the individual is not dying because (s)he appears to be breathing.
Bobrow, Zuercher, Ewy, Clark, Chikani, Donahue, Sanders, Hilwig, Berg, and Kern (2008), reported that “bystanders’ or emergency medical dispatchers’ delay in recognizing cardiac arrest because of the presence of gasping or other forms of abnormal breathing in the early stage of [cardiac] arrest” (p. 2550).

Research has shown that bystanders, including physicians and LEOs, will often delay performing cardio-pulmonary resuscitation (CPR) on an individual because (s)he is gasping or making other breathing sounds (Bobrow, Zuercher, Ewy, Clark, Chikani, Donahue, Sanders, Hilwig, Berg, & Kern, 2008).

Because some people may suffer cardiac arrest and/or ventricular fibrillation after struggling with LEOs or after running away from them, it is important LEOs have training about agonal breathing and its sounds.

There has been litigation filed against governmental entities alleging they “failed to train” LEOs about agonal breathing, which one could argue is an “essential skill” of LEOs.

APPLICATION

The IPICD recommends the training of 9-1-1 Call-Takers, Dispatchers, and then LEOs about agonal breathing.

According to Eisenberg (2006) 9-1-1 Call Takers and Dispatchers should ask the caller the following two questions in order (the order is essential and the questions must not be combined):

- “Is the person conscious?” and if the caller replies “NO”, then ask
- “Is the person breathing normally?” (p. 189).

Emphasis should be placed on the word “normally” by the 9-1-1 Call-Taker and/or Dispatcher, so the caller can perform CPR with the direction of the Call Taker or Dispatcher.

Research has shown training 9-1-1 Call-Takers, Dispatchers (both part of the EMS system), and others improves their assessments for the detection of agonal breathing when the right questions were asked of the caller or another person (e.g., family member, friend, officer) who was on the scene (IOM, 2015, p. 38; Roppolo, Westfall, Pepe, Nobel, Cowan, Kay, & Idris, 2009; Perkins, Walker, Christensen, Hulme, & Monsieurs, 2006). Therefore, it is strongly recommended that 9-1-1 Call-Takers, Dispatchers, and LEOs be trained about agonal breathing and its sounds to minimize
“failure to train” and/or “negligent training” claims in litigation, and more importantly, save lives!

4.26 A few breaths, gulps, or gasps in an unconscious person should not be mistaken for adequate breathing. **This is a medical emergency.**

4.27 Likewise, abdominal and/or chest movement may not be a sign of adequate breathing.

4.28 If an unconscious person makes any of the following noises, this may be a sign of agonal breathing, and a sign that death is near: snoring; guttural; grunting; gasping; or gulping.

4.29 LEOs must also be trained about agonal breathing and its sounds, because they are often the first responders to come into contact with the individual suffering from cardiac arrest.

4.30 LEOs must understand that agonal breathing may sound like “snoring” or “gasping” for air.

4.31 LEOs must also be taught that agonal breathing may follow cardiac arrest.

4.32 LEOs must be taught to perform CPR on the individual, and to not mistakenly believe the person is not in need of immediate medical care.

4.33 LEOs must be presented with the sounds of agonal breathing so they are familiar with not only the medical emergency concept, but also with its sounds.

4.34 These events are medical emergencies and emergency medical services must be summoned immediately.

4.35 LEOs who are going to perform CPR on an individual must be current and certified in CPR, or ask a Dispatcher who is certified in CPR to provide step-by-step instructions on how to perform CPR.

4.36 LEOs need to earn their AED certification and keep it, along with their CPR certification, during their careers (Bozeman & Stopyra, 2015).

4.37 Lesson 5 discusses “Best Practices” for situations involving people with breathing difficulties.

**NOTES:**
LESSON 5: BEST PRACTICES

BREADTH

5.1 It should be clear by this point in the online program that there have been several arrest-related deaths where suspects told LEOs they had breathing difficulties, and other situations where individuals subjectively told LEOs they were having breathing problems.

5.2 Based upon informal surveys of LEOs by IPICD staff of LEOs who attended various IPICD training programs, few LEOs have been trained by their governmental entities about ventilation, oxygenation, agonal breathing, and intervention strategies.

5.3 Training LEOs about these concepts may eliminate or minimize criminal and/or civil litigation being filed against officers and governmental entities alleging “failure to train” or “negligent training,” and more importantly, save lives.

5.4 Recall that research showed that training of 9-1-1 Call-Takers, Dispatchers, and others improved their assessments for the detection of agonal breathing when the right questions were asked of the caller or another person (e.g., family member, friend, officer) who was on the scene (IOM, 2015; Roppolo, Westfall, Pepe, Nobel, Cowan, Kay, & Idris, 2009; Perkins, Walker, Christensen, Hulme, & Monsieurs, 2006).

DEPTH

5.5 Civil litigation that alleges governmental entities failed to train their LEOs about human ventilation, respiration (oxygenation), and agonal breathing will continue to grow.

5.6 Defending such litigation can be a very costly process, which may include depositions and other legal costs, including settlements prior to trial or a jury verdict for the plaintiff.

5.7 As an example, Legal Bay, LLC (2015) reported in July 2015 that Mr. Garner’s family had agreed to a $5.9 million settlement from the City of New York.

5.8 How much training could have been conducted by the City of New York for $5.9 million?

APPLICATION

5.9 Governmental entities must train their public safety employees about ventilation, respiration, and agonal breathing to not only avoid or minimize civil litigation, but also to save lives.
5.10 Officers who “notice” a person’s abnormal breathing must consider there might be a medical problem taking place.

5.11 One breath, erratic or labored breathing, a gulp, and/or gasping are signs of serious trouble and public safety personnel must act to help.

5.12 Remember to allow for good ventilation, which will allow for good oxygenation.

5.13 When a conscious person complains of or demonstrates breathing difficulties:
   a. Do not make thoughtless comments. Breathing problems can cause significant anxiety in those individuals experiencing breathing problems and also for those nearby. Take care to not express your anxiety in thoughtless works or acts;
   b. Provide for fresh air (e.g., provide O₂, reposition, etc.);
   c. For those individuals who have a possible head, neck, or back injury, if necessary, re-position them to make sure they have an open airway for ventilation (consider using the Jaw-thrust maneuver, if qualified and appropriate);
   d. Call EMS if the person requests it, or if you are concerned;
   e. Treat breathing difficulties as medical emergencies;
   f. Reassure the person and attempt to keep the person calm;
   g. Demonstrate concern for the individual and for family members and friends.

5.14 When interacting with an unconscious person or a person with a decreased level of consciousness or alertness:
   a. Treat the situation as a medical emergency and immediately request EMS;
   b. For those individuals who have a possible head, neck, or back injury, if necessary, re-position them to make sure they have an open airway for ventilation (consider using the Jaw-thrust maneuver, if qualified and appropriate);
   c. Clear the airway of obstruction (if necessary);
   d. For those individuals who are not seriously injured and can be safely rolled onto their side, position their body in the Recovery Position;
   e. If the person is not breathing or not breathing adequately, begin resuscitation;
   f. Demonstrate concern for the individual, for family members, and for friends.
5.15 **In general** on scene:

a. Recognize the value of good supervision and/or senior officer leadership;

b. Request a supervisor to the scene;

c. Ask for expert assistance;

d. Professionally manage your anxiety and the anxiety of co-workers;

e. Demonstrate concern for the individual, for family members, and for friends;

f. Do not erroneously mistake unconsciousness for “compliance”;

g. A person’s mental confusion may be an early sign of inadequate oxygenation;

h. A person with breathing difficulties may be unable to comply with requests and commands;

i. Always manage risk (e.g., injury to you, the suspect, and bystanders).

j. Train those officers who often respond to the media (e.g., Public Information Officer) about ventilation, respiration, and agonal breathing so (s)he will not say something like, “If he’s talking, he’s breathing.”

k. If a person vigorously uses his or her abdominal or neck muscles during exhalation this indicates breathing difficulty or even respiratory distress.

l. Maintain CPR and AED certifications during the LEO career (Bozeman & Stopyra, 2015).

5.16 Governmental entities must:

a. Train public safety personnel about ventilation, respiration, breathing difficulties, and agonal breathing;

b. Train 9-1-1 Call-Takers and Dispatchers to ask the following two questions in order: “Is the person conscious?” and if the person replies “NO”, then ask “Is the person breathing normally?”;

c. Develop a protocol to share this information with responding LEOs;

d. Incorporate training about breathing into high-risk training programs, such as defensive tactics, restraints, electronic control weapons, pepper spray, etc.

e. Equip patrol cars with AEDs, and train LEOs in CPR and in the use of AEDs.
5.17 Please review the “Summary” that is in the next section of the online program.

5.18 After reviewing the “Summary,” please take the online “Assessment.”

5.19 Thank you for taking this online program, and wish you the best of success.

NOTES:
REFERENCES


INSTITUTE HISTORY

The Institute for the Prevention of In-Custody Deaths, Inc. (IPICD) was founded by John G. Peters, Jr., Ph.D. in the spring of 2005 with its sole purpose to educate interested parties about arrest-related deaths. A former police administrator, police officer, and current international trainer, Dr. Peters had been teaching a one-day program that focused upon the identification and prevention of in-custody deaths as early as the 1990s, and thought it time to specialize in this area. To date, the IPICD has trained thousands of individuals as instructors in this specialized topic, and has expanded its training programs since its founding.

IPICD Online Training Center: In the summer of 2014 the IPICD launched its “IPICD Online Training Center.” Innovative, cost-effective, instructive, and requiring no travel or per diem costs, IPICD online programs provide the information needed for IPICD instructor graduates to update and maintain their instructor status, and for others to be trained in arrest-related and sudden in-custody death topics.

IPICD Center for Excellence in Event Reconstruction (CEER): CEER is a clearinghouse, resource center, educational, and training provider dedicated to supplying interested parties with objective, timely, scientifically- and operationally-based qualitative and quantitative information, training, and operational guidance about event reconstruction involving use-of-force, camera-based systems, arrest-related deaths, sudden in-custody deaths, and other high-profile events involving law enforcement officers.

Created in 2015 as a branch of the Institute for the Prevention of In-custody Deaths, Inc. (IPICD), the CEER hosts symposia and other risk management educational and training programs addressing the legal and administrative issues facing governmental entities, administrators, and other stakeholders in reconstructing and analyzing high-risk events. Many times these incidents involved use-of-force, domestic violence, workplace violence, arrest-related deaths, sudden in-custody deaths, and other liability-enhanced and/or community-sensitive situations. Event data are increasingly captured using camera-based systems such as body-worn cameras, robots, unmanned aerial vehicles (UAV), or jail cameras.

The CEER also offers contemporary specialized certifications to law enforcement officers, expert witnesses, and others who successfully complete select programs. These designations often enhance the breadth, depth, and credibility of those who complete the CEER intensive programs about how to reconstruct specialized events. Many of these programs are offered in partnership with the Institute for the Prevention of In-custody Deaths, Inc. and/or its online training center.

CEER held the first international symposium on law enforcement camera-based systems in June 2015, which was attended by over 200 law enforcement professional, researchers, expert witnesses, and lawyers from across the globe.
**IPICD Center for Digital Strategy**: Launched in 2015, the Center for Digital Strategy is designed to develop a digital strategy for the IPICD through various digital outlets, including the IPICD Online Training Center.

**Institute Mission Statement**

The Institute for the Prevention of In-Custody Deaths, Inc. (IPICD) is a clearinghouse, resource center, and training, and litigation assistance provider dedicated to providing interested parties with objective, timely, accurate, qualitative, and quantitative information, training, and operational guidance for the prevention and management of sudden- and in-custody deaths.

**Institute Staff**

*John G. Peters, Jr., Ph.D., CTC, CLS* serves as the President and Chief Learning Officer of the Institute for the Prevention of In-Custody Deaths, Inc. He has served as Training Advisor to the AMTRAK® Police Department, and is a former member of the United States Secret Service Defensive Tactics Advisory Panel. Dr. Peters, former training advisor to the El Paso County (CO) Sheriff's Department, the Routt County (CO) Sheriff's Department, the Pulaski County (AR) Sheriff's Department, and the Fairbanks (AK) Police Department, was also retained by a large Texas Sheriff’s Department to serve as a monitor of a U.S. Department of Justice Civil Rights Investigation of its large jail facility.

A former police officer and deputy sheriff, he also served as Staff Executive (civilian equivalent of Deputy Chief) of a mid-sized police department, where he headed the Administrative Bureau (seven divisions) and directed the Planning and Research unit. Dr. Peters also conducted internal investigations, handled media relations, and reviewed and wrote agency policies. A former employee of the Federal Bureau of Investigation, Dr. Peters received a *Letter of Commendation* for his Judo instruction while employed.

Educationally, he was awarded an Associate in Applied Science degree (police science) and a Certificate in Corrections, both *Cum Laude*, from the Northern Virginia Community College; a Bachelor of Science degree (criminal justice), *Summa Cum Laude*, from the University of Baltimore; a Master of Science degree (public relations) from Boston University; a Master of Business Administration degree, *With Distinction*, from Babson College; and, the Doctor of Philosophy degree (applied management and decision sciences, with an emphasis in criminal justice) from Walden University. He is also a Certified Online Instructor, and has taken several postgraduate courses, including a 2005 specialized seminar on sudden and in-custody deaths designed for and taught by emergency room doctors. In June 2012, Dr. Peters earned his CLEAR California teaching credential, and in 2013 was awarded a *post-doctoral* Master of Arts degree in Education (Career and Technical) from California State University, San Bernardino—Palm Desert Campus.

In 2006, Dr. Peters earned the Certified Litigation Specialist (CLS) designation of the Americans for Effective Law Enforcement (AELE), and is one of very few professionals who
completed the requirements for CLS in each AELE category: Police Liability; Corrections Liability; and, Public Sector Employment Liability. In 2009 Dr. Peters renewed these CLS designations, and in 2010 he completed the CLS for Campus Law Enforcement.

Dr. Peters has taught statistics, research methods, quantitative methods, public relations, instructional design, and business subjects at both the undergraduate and graduate levels. He has served on several doctoral- and master-degree committees, and has been a faculty advisor to both doctoral- and master-level psychology learners. He is also faculty for Americans for Effective Law Enforcement seminars. Dr. Peters is also an adjunct faculty member at the University of Phoenix, School of Criminal Justice and Security, and College of Business, Las Vegas.

In addition to having taught statistics and research methods, Dr. Peters has conducted statistical analyses on excited delirium incidents, TASER® electronic control device deployments, racial profiling, sexual harassment, The WRAP Restraint, and other law enforcement data. Dr. Peters has also authored, “Science and Logic Meet the Law”, in Conducted Electrical Weapons: Physiology, Pathology, and the Law (2009, Springer).

As the senior trainer and instructional designer, for and president of, the internationally recognized teaching firm, Defensive Tactics Institute, Inc., he has over 26 years of experience teaching tactics, impact tools, defensive tactics, and courses providing operational guidance to criminal justice agencies across the United States, Canada, and England. He has taught Instructor-Trainer and/or Basic programs in oleoresin capsicum (OC)sprays, tactical handcuffing, expandable baton, Pneu-Gun Ballistic Baton, electronic restraints, defensive tactics, side-handle baton, Kubotan®, tactical flashlight™, tactical rope and rescue, firearm retention, use of force, policy development, prevention and management of sexual harassment, and managing use-of-force issues. Dr. Peters is also a graduate of several TASER® electronic control weapon (ECW) Instructor and specialized programs (i.e., the Armorer program, the Evidence Collection and Analysis Training program, the X3™ ECD, the XREP™, the AXON™, and Evidence.com™) and has experienced a five-second ECD exposure.

Dr. Peters has written over 250 publications that include articles, book chapters, lesson guides, and books, informational videos, and has developed several online courses for universities. Several of his excited delirium articles have been referenced in law enforcement texts and studies (see Williams, TASER Electronic Control Devices and Sudden In-Custody Death: Separating Evidence from Conjecture (2008), and Rostker, et al., Evaluation of the New York City Police Department and Firearms Training and Firearms-Discharge Review Process, 2008 [Rand® Corporation].

Dr. Peters also consults and testifies as an expert witness, and has also been judicially qualified as a law enforcement practices, products, and/or product warnings expert in international (China), federal, and state courts in more than 300 cases. Many of these cases focused upon sudden death, excited delirium, alleged excessive use of force, positional asphyxia, jail suicide, policy issues, training, handcuffing, sexual harassment, restraint asphyxia, product warnings, pepper spray, etc.
A. David Berman, M.S., CLS is a former patrol officer, instructor, and member of the Emergency Services Unit for a northeastern Pennsylvania police department. A nationally-recognized defensive tactics and impact tool instructor, David has taught non-lethal and less-lethal instructor and basic programs to police, correctional, military, and security officers across the United States. A National Rifle Association-qualified firearms instructor, he has the street experience to separate theory from reality.

Educationally, David graduated from Bowling Green State University (Ohio) with a Master of Science degree in criminal justice, and obtained his Bachelor of Science degree in education from Wilkes University. A graduate of the Commonwealth of Pennsylvania Basic Police Training Course, and has also completed several specialized criminal justice courses.

In 2006 and 2007, David completed the requirements and earned the Certified Litigation Specialist: Police Liability designation in January 2008, awarded through the Americans for Effective Law Enforcement (AELE). In 2011 he completed the CLS requirement for Campus Law Enforcement. David was the second IPICD staff member to have earned this distinguished certification.

Co-developer of the Defensive Tactics Institute, Inc. Tactical Glove® Instructor Course, he is also co-author of the Tactical Glove Review Poster with John G. Peters, Jr. He has served as a script consultant for several informational videos, including Defensive Tactics with Chemical Aerosol Sprays, Personal Protection with Chemical Aerosol Sprays, Stop Exposing Yourself, Reducing Personal Risk through Leather Gloves, and Prevention and Management of Sudden In-Custody Death with John G. Peters, Jr. He was a featured presenter in the latter two videos, and also made an appearance in another video, Pneu-Gun Ballistic Baton.

A lively and energetic instructor, David had taught in the Pennsylvania Act 120 program, Basic Municipal Police Continuing Education program for Pennsylvania Constables. He is also an Instructor-Trainer for Combined Tactical systems (CTS) and Stinger Spike Systems, and has over 20 years of experience in police equipment and gear. He has also served as an Expert Witness in several cases where it was alleged that police officers used excessive force. David is the co-author of the text Prevention and Management of In-Custody Death, with John G. Peters, Jr. David has also published on PoliceOne.com and in other professional publications. He is currently writing articles that focus on keeping officers safe on the street and in the courtroom.

Jason Peters, A.A.S. serves as the Director of the Center for Digital Strategy, as Informational Technology Specialist, and as Administrator Coordinator. A graduate of ITT—Las Vegas, Jason has consulted with several Las Vegas-based businesses on information technology issues.

Christopher J. Loretz serves as Graphic Designer for the IPICD. A graphic arts graduate of Millersville University, “Chris” designed the IPICD workbook covers, print media, and many training aids for the IPICD.
INSTITUTE BOARD OF DIRECTORS

William D. Steeves, Jr., Ed.D., retired from the United States Marine Corps, and then entered corporate life, eventually leaving it for higher education. A professor of management and leadership, Dr. Steeves also has law enforcement knowledge and experience having proudly served in the United States Marine Corps Security Guard Battalion, stationed in Jordan. Dr. Steeves earned his doctorate from George Washington University, and lives in Northern Virginia and in upstate Michigan.

Charles Wilhite, J.D., a Lieutenant with a large California law enforcement agency, joined the IPICD Board of Directors and manages its Litigation Assistance Center, and is the Director of the IPICD Center for Excellence in Event Reconstruction (CEER). A graduate of several IPICD programs, Lt. Wilhite is a licensed attorney and also a doctoral candidate in Psychology.

Chief Tommy Burns, M.A. (Ret.), has extensive casino gaming security experience, and has been judicially-qualified as an expert witness in security and police practices, and is a faculty member in the School of Criminal Justice and Security at the University of Phoenix, Las Vegas.

Donald L. Leach, II, Ph.D. is a retired correctional administrator who does training and consulting work across the United States. Dr. Leach has extensive experience in jail management and in developing objective jail classification systems, and as a Public Information Officer. An expert witness on correctional issues, Dr. Leach resides in Utah.

Robert Willis’ law enforcement and instructional career has spanned over 30 years. As an officer and an instructor he has trained federal, state and local agencies and officers. For 10 years, Bob co-presented the Calibre Press Street Survival® Seminar across the USA and Canada and contributed to Calibre Press books and videos. Bob has been a patrol officer, "SWAT" team member, field training officer, defensive tactics coordinator, departmental training officer, recruit academy and in-service academy instructor, instructor certification specialist, professional officer survival instructor and a litigation consultant. Bob is now a full-time Instructor at Northeast Wisconsin Technical College in Green Bay, WI. where he is also a sworn Brown County Deputy Sheriff. He is a State of Wisconsin "master instructor" and is responsible for training numerous public safety instructor development programs and law enforcement officers at a state-of-the-art, scenario based tactical training facility located on the "NWTC" campus.
ABOUT THE AUTHORS

*Sergeant Brian Casey,* co-author of the Institute’s “One Breath . . .” online program is a sergeant with the St. Paul (MN) Police Department where he serves as the director of its Employee Assistance Program. Sergeant Casey earned a degree in Health Education from the University of Minnesota, and has over thirty years’ experience working as a paramedic, EMS educator, and police officer.

*John G. Peters, Jr., Ph.D., CTC, CLS* serves as president and chief learning officer of the Institute. A former police administrator, police officer, and deputy sheriff, Dr. Peters has been judicially qualified as an expert witness in state, federal, and international courts. An instructional designer with over 30 years of experience, he has authored over 250 publications, including the following texts: *Realistic Defensive Tactics, Tactical Handcuffing for Chain- and Hinged-Styled Handcuffs, Official Kubotan® Techniques,* and *Defensive Tactics with Flashlights.*