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Preventing Civil Unrest: Transitioning from Prisoner to Patient

The tragic death of George Floyd serves to remind us that there still exists systemic failures in law enforcement leadership, in policy development, in training, and in supervision.

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Many police trainers and experts will say Mr. Floyd's arrest-related death is a "once in a career event." Statistically, this claim is mathematically correct, but, to the four involved Minneapolis Law Enforcement Officers (LEOs), it is a "career-ending event" and, lest we forget, it is a "life-ending event" for Mr. Floyd. Statistical probabilities mean little, if anything, when you become the statistic.

Focusing only on Mr. Floyd's death (outcome) is misleading because there is other evidence impacting the "outcome." Evidence (inputs) include a policy permitting the placement of a knee on a prisoner's neck area; training which reinforced the policy and ignored medical warnings about the dangers associated with this practice; leaders who permitted and ratified this policy; and supervisors who failed to prohibit this dangerous restraint policy, custom, or practice on their shifts. Connecting the policy, training, leadership, and supervision dots clearly show organizational system failures and the need for an audit of these policies, practices and previous force outcomes.

To those people who question Mr. Floyd's asphyxia autopsy suggestions, point to illicit drugs identified in his system, or his testing positive for COVID-19 (postmortem) to deflect or justify the officers' actions and/or inactions, please refocus on the three words repeated by Mr. Floyd 12 times which were ignored by the LEOs: "I can't breathe."

Contemporary, forward-looking leaders, trainers and officers know that when a restrained person utters, "I can't breathe," this is first and foremost a *medical emergency*. Emergen-

cy Medical Services (EMS) must be immediately summoned along with an attitude shift that "I am now interacting with a patient who is having a medical emergency." The medical emergency must take precedence over arrest procedure. Instilling and reinforcing this paradigm into the minds of officers takes place through leading-edge leadership, scientific-based policy and training, and proactive supervision.

Most LEOs cannot make diagnoses about a person's physical or mental health because they lack the necessary training and qualification. Such diagnoses are better left to other qualified individuals. In contrast, LEOs and supervisors both need training (or refresher training) on how to recognize medical emergencies. Steps include: Stop, look and listen.

Briefly stopping to assess the situation and/or the person is an important and simple way to potentially identify a medical emergency. For example, LEOs may develop "tunnel vision" during the restraint process and miss the prisoner going "nonresponsive" and needing immediate medical care. Too often, supervisors fail to supervise because they are involved in helping LEOs capture and control the individual, but they need to disengage and *supervise*. This "failure to supervise" becomes another "count" in the civil complaint when the plaintiff alleges this failure attributed to the serious injury or death. When LEOs stop for a moment and assess the situation and/or the suspect, this usually slows the *pacing* (speed) of the event, allowing time for assessment of force options and/or tactics.

Visually scanning the individual during and after the capture, control and restraint process may help identify a medical emergency. A combative suspect who suddenly quiets down and stops fighting may indicate a medical emergency.

Recognizing Medical Emergencies

Listening to a restrained individual's complaining of injury is easy, but some LEOs ignore or fail to act on such complaints because "it is not my job" or "she's faking it." Recently, a large Pennsylvania city, along with its former police chief and involved LEOs, lost a jury trial where the plaintiff alleged that officers ignored her pleas of injury during and following her arrest and the former police chief failed to conduct a meaningful internal investigation thereby ratifying the officers' conduct.

The officer who allegedly injured her (who was also certified as an EMT) told the court he took her to the jail, thereby transferring her "care" to jail staff. At trial, she proved her serious injuries and that the LEO-EMT ignored her injury complaints. The LEO admitted his failure to follow agency policy about providing medical assistance even though he is EMT-certified.

In another case, a LEO testified at deposition that he did not want to take the suspect to the hospital because he would have to "babysit" him for several hours. Tragically, the suspect died in jail shortly after the LEO dropped him off at the jail. Instead of "saving" time, after the officer sat through his and other LEOs' depositions following a civil suit, the four hours he tried to avoid paled in comparison. The LEO knew the suspect had a medical issue, yet failed to take appropriate intervention.

LEOs should be given training regarding how medical emergencies can arise and that injury-causing emergencies can occur to suspects and others when LEOs effectively use restraint devices and techniques. Injury-producing devices and techniques include:

- **Electronic control weapons** can cause eye, groin and breast injuries when the probes strike and penetrate these areas. The manufacturer warns users of rare cardiac-associated injuries which may become fatal.
- **Metallic and similar restraints** have caused nerve and other injuries to individuals after improper application.
- **OC, CN and CS sprays** have caused corneal burns and abrasions (associated with pepper spray), while blistering and burns to the skin are associated with tear gas sprays (CN and CS). Breathing issues are associated with the three sprays.
- **Choke holds** remain very controversial and have serious injuries and deaths associated with their use. On June 5, 2020, California Governor Gavin Newsome ordered California peace officers to stop using them.
- **Prone restraint** – Asphyxia from death is arguably associated with prone restraint, but scientific research studies fail to support the fatal outcome. Applying a knee on the neck can cause cervical spinal injuries and, in rare cases, death. Too much weight on a person's back may cause shoulder, back and spinal injuries and, in rare cases, death.
- **Kinetic impact munitions,** flexible (bean bags) and inflexible (rubber pellets and wooden dowels), can cause serious injury and, in rare cases, death. Research shows that these munitions, which are commonly used in crowd control settings, have caused injuries to the head, neck and torso areas, including death from trauma.
- **Distraction devices** such as flash bangs can potentially cause serious eye and burn injuries.

Organizational Diagnosis: Identifying Problems and Solutions

Command officers, trainers and investigators need to perform a focused organizational diagnosis (audit) identifying failures and potential problems in policy, training, reporting, and investigating force events and then develop solutions. For example, are policy and training based on scientific findings, legal outcomes and evidence-based practices? If not, why not? Here are some areas to perform an audit:

Policy and training – Minneapolis Police Department policy and training sanctioned putting a knee on a suspect's neck despite overwhelming scientific and legal documentation to the contrary. Command officers and trainers have an obligation to keep aware of scientific knowledge about force options and change their policy and curricula to parallel the science (e.g., placing a knee on a neck). They must also work as a team and not as individual "turf defenders" protecting their fiefdom from change. Yes, it will take some work, but that is why leaders and trainers are in these positions. Rele-

vant scientific findings should cause capable trainers to update their lesson plans, and share the information with command officers and all LEOs, during or after command officers change affected policies and procedures. This takes time and effort. However, sitting in federal or state court for days or weeks during a criminal or civil trial involves a lot more work. Knowledgeable command officers and trainers are positive change agents for their agencies and communities.

"Business as usual" is no longer a leadership option. A small number of states have statutes allowing new officers to work the streets for at least one year before attending a police academy. Leadership can follow state statute and allow untrained LEOs to work, but this is not a safe practice for obvious reasons.

Similarly, many officers are promoted to supervisor or another management level and supervise others without attending a supervisory or command school. While most LEOs will not work with an untrained LEO, many are quite comfortable knowingly working with an untrained supervisor who will evaluate their performance for continued employment. Training is not a magical solution, but it makes supervisors and trainers aware of advancements and evidence-based practices they need to consider for their agencies and officers – regardless of agency size.

Force options – Medical emergencies sometimes follow a LEO's use of force. Are officers trained to *stop, look* and *listen* for visible signs of injury and complaints of injury by the suspect or from others during and after using force? Train LEOs to pause and *look* at the individual during restraint to make sure the person is breathing and is responsive. *Listen* to the person when complaining of injury, or when told by others who perceive injuries, particularly if the person says, "I can't breathe." Visible signs of injury, becoming nonresponsive and complaints of injury are medical emergencies which take precedent over the arrest procedure.

Identify unwritten ground rules – Unwritten Ground Rules (UGRs) show the "actual" culture of the organizational unit and/or the organization and, in many cases, what a LEO "can get away with while working." Supervisors must be diligent in their supervision and leaders must make sure every member keeps the organization's overall mission in mind. Too often, the actual rules followed on the street are not in keeping with the agency's published "mission" on its Web site or published policies and procedures.

Some supervisors are strict and make LEOs follow training and agency policy. Other supervisors are lax and let subordinates do most anything in the field. These diverse forms of supervision create confusion for officers. There must be a uniform approach to supervision throughout the organization to maintain stability and procedures. Leaders must take time to identify UGRs (e.g., not providing medical care for a suspect who complains of injury; not double-locking handcuffs; incomplete force reports) and supervisors must work on the elimination of such practices. Correcting these and other problems is up to the leadership, but realignment with agency mission and values involves everyone inside the agency.

A seeming universal UGR discourages LEOs to **intervene** or report when a fellow officer does something wrong or uses too much force. Training and supervision must remind LEOs to actively intervene and those supervisors who chastise officers for reporting officers who they perceive abuse their power or authority or use unnecessary force need to be removed from supervisory duties until retraining on this and collateral issues is completed. The LEOs not on Mr. Floyd's back needed to know they must intervene and, if necessary, push the senior officer off Mr. Floyd.

Audit for implicit bias – The infamous and late attorney Johnnie Cochran, Jr. told a story of a Los Angeles Police Department (LAPD) officer stopping him late at night. When Mr. Cochran asked the officer the reason for the traffic stop, the officer replied, "Well, Mr. Cochran, black people don't drive a Rolls-Royce®." Cochran often used this story to illustrate implicit bias in law enforcement situations.

Everyone has biases and prejudices – be it against tomatoes or going to the movies. Some individuals have preconceived biases and prejudices against people of color (think Native American); against people practicing a religion (think Jewish); or against one's home state or country (think Middle East). Bias training does not guarantee biases and prejudice elimination, but it is a step in the right direction. Implicit bias may not contribute to a medical emergency, but it may affect a LEO's response to the person experiencing one.

Summary

LEOs, by law, have one half the power of God: the power to take a life when appropriate and necessary. In contrast, statutes, policies and other authority cannot give LEOs the most important other one half: restoring life. It is up to leaders, supervisors and trainers to audit the organization to identify policy, training, supervision, leadership, and investigative failures and potential failures, and then correct them through policy and training changes. LEOs must be given contemporary training on how to identify medical emergencies which will minimize serious injury or death to suspects.

The tragic death of Mr. Floyd, rather than proactive organizational audits, exposed systemic failures we all know exist in law enforcement agencies. His death showed the continued need to train officers in techniques and policies which reduce injury to suspects, not increase it, and how to identify and respond to medical emergencies. Training officers (action) about how to identify "medical emergencies" and how to transition in their thinking from prisoner to patient are mission critical. **P&SN**

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