P&SN Police and Security News
Serving Law Enforcement & Homeland Security

As seen in the September/October 2025 issue of Police and Security News.

Restraint, Risk and Responsibility: Advancing Safety in Policing

How can law enforcement agencies implement a culture of safety to prevent restraint-related deaths and ensure timely intervention when a detainee shows signs of distress?

Photo by Lindsay Beyerstein

JOHN G. PETERS, JR., PH.D.

Following a controlled drug transaction with an undercover officer, a surveillance team moved in to make an arrest. Upon noticing marked police vehicles approaching, the suspect exited his vehicle and ran across a rain slicked grassy strip situated between a sidewalk and a chain-link fence. Officers pursued him and, after he slipped and fell, multiple officers used their body weight, hands and knees to restrain him on the ground while attempting to handcuff his arms behind his back. During the restraint, the young minority male repeatedly stated, "I can't breathe," but these statements were disregarded. Once handcuffed and lifted to his feet, he was placed securely into the rear compartment of a police SUV. A supervising sergeant asked, "Shouldn't someone watch him?" An officer replied that the in-car camera would monitor the detainee. Officers then left the vehicle to discuss the incident. The entire event was captured on body-worn cameras.

A sudden stop in resistance may seem like compliance, but officers must remain alert to the possibility that the individual is no longer breathing or has died.

In a separate video recorded encounter, a young male – shirtless and handcuffed behind his back – was placed in the rear seat of a patrol car. The individual began experiencing breathing difficulties and can be heard repeatedly telling an officer, "I can't breathe." The officer responded by dismissing the claim, stating, "You're lying." The young man became nonresponsive.

Both individuals passed away, resulting in civil litigation. Had an officer been properly trained to detect behavioral changes and intervene, their deaths could potentially have been avoided.

Taking a Cue from the Medical Profession

The medical profession has had its share of patients expiring while being treated. In a landmark 1999 study conducted by the Institute of Medicine (US) Committee on Quality of Health Care in America and published in 2000, researchers estimated that a significant number of deaths in hospitals were due to *preventable* medical errors, bringing patient safety to the forefront of public and policy attention. It emphasized that errors are often systemic rather than solely individual failures. This study supported and reiterated the "Harvard Medical Practice Study" findings of Brennen and Leape (1991). Many of these findings and recommendations can be applied to public safety.

Continued from page 1

Civil lawsuits alleging "deliberate indifference to medical needs," "failure to train," or "negligence" have risen sharply, often resulting in substantial jury awards.

In a previous edition of *Police and Security News*, it was discussed how quickly a detainee can become a patient (see July/August 2020, "Prisoner to Patient"). When a prisoner suddenly "stops resisting," the officer(s) may feel a sense of relief that commands to stop resisting are being obeyed, only to discover the person is deceased. Apparent compliance may conceal serious risk, so it is important to not assume anything about the person's well-being.

Assessing the Problem

Like hospitals, analyzing critical police incidents, near misses (e.g., respiratory distress) and complaints through a system-oriented lens can help identify organizational factors contributing to errors or safety risks. Technical proficiency (think handcuffing, grounding, defensive tactics) alone is insufficient. Suspect and prisoner safety initiatives increasingly emphasize nontechnical skills such as communication, teamwork, leadership, situational awareness, and decision-making.

Emphasis on Suspect/Prisoner Safety

Safety concerns about using metallic restraints, chemical agents (including pepper spray), electronic control weapons, canines, heavy-duty flashlights, and rubber projectiles on humans have been associated with public safety for decades. Today, there appears to be a greater emphasis on civilian/suspect/prisoner safety by the public following the deaths of George Floyd (2020); Roy Scott (2019); Freddie Gray (2015); Eric Garner (2014); and, most recently, the uses of force during immigration seizures. Civil litigation targeting "deliberate indifference to medical needs," "failure to train" and/or "negligence" have dramatically increased, along with large monetary awards by juries. Criminal prosecutions of public safety personnel have also increased, with many police officers being found guilty and then sentenced to jail following the temporal death of the individual. There are also legislative mandates.

Legislative Mandates

The states of California, Colorado and Minnesota have passed legislative mandates requiring police officers to observe a person for signs of asphyxia. To minimize potential liability created by these mandates, officers must become competent and qualified in *knowing and understanding* how and what to watch for and identify signs of asphyxia. Of course, there are other important observations to make, too, such as telling officers to remove pressure from a person who has stopped resisting after being handcuffed, but it requires training and competency qualification. Hawaii and New York currently have pending legislation similar to the other three abovementioned states.

Reducing Safety Concerns

Now is the time to examine how to increase civilian/suspect/prisoner safety during public safety involvement. Since the medical profession dealt with a similar problem, the World Health Organization (WHO) developed a "patient safety program" which created "Patient Safety Officers." The roots of the Patient Safety Officer point to the Hippocratic Oath principle of, "First, do no harm."

In September 2024, the Police Executive Research Forum (PERF) published *Principles for Reducing the Risk of Restraint-Related Death*. This report advocates the creation of medical-behavioral emergency response which involves the designation of a Patient Safety Officer. However, to be truly effective, this role must evolve beyond mere designation. It requires a structured framework, organizational cultural change, comprehensive training, and clearly defined responsibilities.

In high-stress situations, officers may overlook critical indicators of human crisis. For example, a prone subject who is not actively resisting may still be at risk of asphyxia, especially when displaying or verbalizing distress such as "I can't breathe." In such moments, a designated, trained and qualified officer must be empowered – and prepared – to intervene decisively, instructing officers to reposition the individual or cease physical contact, and/or contact EMS.

Moreover, the role demands *situational awareness* which extends beyond immediate physical restraint. A handcuffed person placed near the exhaust of a running patrol vehicle may face respiratory hazards which are not immediately obvious. Recognizing and mitigating such risks requires specialized knowledge and vigilance.

Creating a Culture of Safety

Per the National Academy of Sciences (2004), "[a] culture of safety is defined . . . as an integrated pattern of individual and organizational behavior, based upon shared beliefs and values, that continuously seeks to minimize patient harm which may result from the process of care delivery." Recall that it only takes a second or two for a suspect or citizen with whom an officer is engaged to transition into a patient.

Critical thought must be given to creating a "culture of safety." Using labels (e.g., Patient Safety Officer) may exacerbate problems, not resolve them. For example, civilians may expect public safety Patient Safety Officers to have medical or behavioral training, like hospital Patient Safety Officers. Policing is different than the medical profession in many ways and mimicking the latter or mandating that officers become EMTs or paramedics may create dual roles for officers which are unfair, unsustainable and undesirable.

There is also a concern about creating a "new" *standard of care* which must be avoided to discourage new civil litigation because of false, misleading or inaccurate information and perception. This and other issues, such as training officers,

It should be noted that, within only a few seconds, an encounter with a suspect or citizen can shift into a medical emergency requiring patient care.

must be included in the calculus of creating a "culture of safety."

Transparency is required in a "culture of safety." Families who have lost a loved one or who had one seriously injured temporal to law enforcement activity must be told what took place; the intended desired outcome of police intervention; and, when available, the cause of death or serious bodily injury. *Data collection and analysis* are critical variables, too, because they can show outcomes and projections. Analysis of these data will indicate whether the "culture of safety" is working, needs tweaking and identify variables beyond agency control (e.g., overdosing, heart issues, etc.).

Summary

Now is the time for public safety agencies to take decisive action and embed a "culture of safety" into every level of their organization. This means more than adopting new policies – it requires a fundamental shift in mindset, behavior and accountability.

Every member of the agency – from the employer and agency head to command staff, first-line supervisors, call takers, dispatchers, and officers – must commit to recognizing and intervening in potentially dangerous actions and human emergencies. For example, excessive weight on a prone individual's back, sudden nonresponsiveness, inability to follow commands, or other distress must be treated as critical events and/or medical emergencies, not routine occurrences.

Actionable Steps for Agencies:

- *Train officers* to identify life-threatening or dangerous situations and signs in suspects, civilians, colleagues, and themselves. One such training program has been developed and is available from the Institute for the Prevention of In-Custody Deaths, Inc. Its "Situational M.O.N.I.T.O.R.™ Specialist" program trains and qualifies officers on how to create a culture of safety, how to monitor, and what to look for, with appropriate interventions.
- *Establish clear policies* which identify the duties of trained and qualified observers who seldom will get involved unless necessary. Guidance must be based upon an organizational culture of safety.
- *Empower trained and qualified observers* to intervene when they witness dangerous practices, such as a person saying, "I can't breathe," or showing signs of distress.
- *Reinforce safety values* through ongoing training, supervision and daily practice.

Smaller agencies (with 50 or fewer officers) may find it easier to implement this cultural shift due to their greater flexibility in training and policy rollout. However, regardless of size, every agency must act now to ensure that safety is not just a priority, but a core value.

The time to act is now. Begin by defining the role of the observer, integrating safety-focused training and treating all signs of distress as medical emergencies. A true culture of safety starts at the top and is sustained through consistent words, actions and reinforcement, and may have saved the lives of the two young males experiencing respiratory distress. **P&SN**

John G. Peters, Jr., Ph.D. is a frequent contributor to Police and Security News *and serves as President and Chief Learning Officer of the Institute for the Prevention of In-Custody Deaths, Inc. (**ipicd.com**). He is the curator and co-developer of a new Institute program, "Situational M.O.N.I.T.O.R™ Specialist" which educates, trains and qualifies officers on how to monitor and identify situations for asphyxia, abnormal breathing and other life-threatening issues. He is also a judicially qualified expert witness who has testified in international, federal and state courts, and is a graduate of the MIT Sloan School of Management and the Computer Science Artificial Intelligence Laboratory (CSAIL) on Artificial Intelligence.*