FINAL REPORT AND RECOMMENDATIONS

OF THE

COMMITTEE ON POLICE USE OF FORCE

Submitted to
Portland Police Chief Penny E. Harrington
on July 18, 1985

COMPOSITION, PURPOSE & SCOPE OF
THE COMMITTEE ON POLICE USE OF FORCE

On April 26, 1985, Portland Police Chief Penny E. Harrington formed the Committee on Police Use of Force. Members of the Committee were:

Reverend Rodney Page, Executive Director, Ecumenical Ministries of Oregon, Chairperson

Kernan Bagley, U.S. Marshall, District of Oregon

Dr. William Brady, Medical Examiner, State of Oregon

Herb Cawthorne, President, Urban League

Carol Edmo, Commissioner, Metropolitan Human Relations Commission

Fred Lenzser, Attorney, Multnomah County District Attorney's Office

Donald Van Blaricom, Chief of Police, Bellevue, Washington

Dr. William Brady resigned from the Committee prior to completion of the study and was not a participant in the final recommendations. The Committee accepted Dr. Brady's resignation with regret.

To assist the Committee in the task before it, Chief Harrington assigned Lieutenant Gary Schrader, Lieutenant Alan Orr and Police Clerical Assistant Karen Hamada, of the Chief's Office, to serve as staff assistants and secretarial support

for the Committee. In addition, many uniform officers assisted Committee members on the "Ride-Along Program". Technical and research assistance was provided by the U.S. Department of Justice, Community Relations Service. The following members of the Department of Justice provided community relations perspectives and research regarding cities of similar size to Portland and use of force within those cities:

Robert Lamb, Regional Director, Seattle, Washington

John Mathis, Conciliator, Seattle, Washington

Atkins Warren, National Administration of Justice Specialist, Washington, D.C.

Gil Hirabayashi, Conciliator, Seattle, Washington

Thelma Carranza, Conciliator, Seattle, Washington

The Committee received assistance from the Metropolitan Human Relations Commission in organizing and conducting a community forum to obtain public concerns and recommendations.

The Bellevue, Washington Police Department Training Unit also provided assistance to the Committee by demonstrating a variety of less lethal devices for control of violent subjects.

The Committee would like to express its sincere appreciation for the open and generous assistance of all the people listed above.

Chief Harrington, in her charge to the Committee, asked the Committee to examine the job requirements of Portland Police Bureau members in regard to the types of force used, to examine the Police Bureau's use of force procedures and training programs, and to make written recommendations to the Chief of Police on whether or not to retain, change or delete any procedure or training program relative to the use of force.

She also discussed her philosophy of use of force with the Committee. She said that society has entrusted the police with the power to take a human life. It is a sacred trust and the police must do everything in their power to safeguard all members of society.

The police must not take a human life unless it is an extreme emergency and there is no other way to protect society. They must also protect innocent persons from the threat of death or serious bodily injury. The police are frequently called upon to make these very serious life and death decisions. All too often, these decisions must be made in an instant. The Police Bureau has a responsibility to provide its officers with the best training possible and with clear guidelines on the use of force. The Police Bureau must make certain that its officers have the necessary equipment and resources to enable them to carry out their duties.

It is the policy of the Portland Police Bureau that officers shall use only that amount of force necessary to overcome any resistance to the performance of their duties. The use of excessive force is a serious offense.

The philosophy of the Portland Police Bureau is that officers are not paid to be assaulted, injured or killed and that they are required to use an adequate amount of force to accomplish their tasks and at the same time to protect themselves and others against injury or death.

The Chief concluded by saying that the Bureau will regularly review its policies regarding the use of force to make certain that they accurately reflect any changes in the law. It will also inspect training policies and procedures to make certain that they keep pace with the current laws and training techniques. In addition, the Police Bureau will review new technologies to make certain that officers have modern, usable equipment.

After discussing the charge and a recent court decision on the use of deadly force [Tennessee v. Garner, 53 LW 4410 (1985)], the Committee decided it would limit its review of force to the mid-levels of force authorized in the Police Bureau's six levels of force. The Committee noted and complimented Chief Harrington on the Police Bureau response to the Tennessee v. Garner case. The Chief had requested the Bureau's legal advisor to review the existing policies regarding deadly physical

force. The existing policies, already more stringent than state law, very closely paralleled the Supreme Court decision. The Chief had already taken the initiative to ensure the Bureau's policies met or exceeded the new standard.

During the review of the Police Bureau's use of force, the Committee heard comments from twenty-three speakers. Training content and techniques were presented by the Police Bureau Training Division. The Bellevue Police Department Training Unit demonstrated a variety of weapons for Committee consideration. Medical aspects of upper body control holds were covered by four doctors (two forensic pathologists and two cardiologists). Legal considerations were presented by both a prosecuting attorney and two civil attorneys. The community relations perspective and comparisons of other cities were provided by members of the United States Department of Justice. The concerns of the Police Bureau's officers were shared by the president of the Portland Police Association and other supervisory and command personnel. The community perspective was obtained through presentations by speakers at the public forum, letters from citizens, comments at the committee meetings, and telephone calls to individual committee members. A list of those speakers is included in Appendix A.

The Committee also heard comments from eleven different speakers at the public forum conducted on June 19, 1985 at Benson High School. A list of those speakers is in Appendix B.

The Committee also reviewed numerous position papers, newspaper articles, magazine articles, training materials, and policies to study the broad spectrum of use of force and alternatives to force. A list of documents examined is in Appendix C.

LEVELS OF FORCE: BACKGROUND

After review of the Police Bureau's levels of force, the Committee focused on the use of the carotid hold. This hold had generated much controversy throughout the nation due to several in-custody deaths which had occurred during or shortly after use of the hold. There was also national controversy on what level of force the hold represented. For these reasons, the Committee conducted an in-depth review of the carotid hold and its application in Portland.

The carotid hold had been used for many years in Portland without injury to the arrestees or officers. In 1985, Portland experienced its first death associated with the carotid hold. Starting in 1972, new officers received training in the application of the hold through the police academy conducted by the Board on Police Standards and Training. Prior to 1972, officers had learned the hold from other officers with whom they worked. In 1983, the Portland Police Bureau included carotid hold training in the in-service refresher training and taught the hold Bureau wide.

In March 1984, the Bureau implemented a procedure which required documentation and supervisory review when the hold was used. Interpretation of the requirement was fragmented and inconsistent. The requirement was modified in October 1984 to clarify whether carotid constriction was applied, whether the subject lost consciousness, whether a pulse check was made, and whether aid had to be rendered.

There were sixty-two reported applications of the hold between March 1984 and April 1985. The Committee examined the uses of the hold for 1984 to obtain a perspective of what circumstances required its use, injuries to the officers, injuries to the suspect, and compliance with Bureau procedures.

Of the fifty times the hold was used in 1984, the majority of incidents revolved around family disturbances and other types of disturbance calls. Appendix D contains a summary of the use of the carotid hold in 1984. In most of the cases, the officers were confronted with a subject using hands, fists, and/or feet as a weapon. Other weapons encountered ranged from a pitchfork to the officer's own police baton.

In thirty-five cases there was no injury to the officer. The most serious injury sustained by an officer during application of the hold was a broken hand. Injuries generally consisted of abrasions and bruises.

Forty-six of the fifty suspects received no injury during the arrest and altercation. The most serious injury sustained was a cut forehead during the struggle.

Carotid pressure was applied in forty-three of the cases. No pressure was applied in five cases, indicating the officer had only placed the subject in a position to apply pressure when the subject ceased resistance. There were two cases in which the reports were not sufficient to make a determination of whether pressure was applied or not.

In twenty-nine cases, the suspect never lost consciousness. Nine suspects were rendered unconscious and there was insufficient information in twelve reports to make that determination.

A pulse check was reported on three subjects. Reports were insufficient to make a determination in twenty-one cases.

The carotid hold was applied to two subjects after they had been handcuffed.

An example of the type of incident in which the carotid hold was authorized and used would be a call to a family disturbance. As the officer arrived, the participants were engaged in a shouting match. When the officer stepped in to separate them, one of the participants continued to pursue

the other one. The person would not respond to the officer's verbal direction and continued to shout and move toward the officer and the other person.

As the officer took hold of the aggressor's arm, the person pulled away, focusing attention on the officer. Within reach of the person was a variety of objects which could be used as a weapon, such as kitchen knives, boiling water, skillet, baseball bat, etc.

When the aggressor again moved toward the officer and the other person, the officer grabbed the aggressor's arm and attempted to place a control hold on the person. As the person tried to pull away, a struggle ensued with the officer and the person falling to the floor. At that time, the other person started trying to pull the officer from the aggressor, shouting "Leave him alone. Don't hurt him." When the officer continued trying to gain control of the aggressor, the other person began striking the officer. At that point, the officer applied the carotid hold, and handcuffed the aggressor. The officer then turned attention to the other participant and tried to calm the situation by verbal commands and minor physical restraint. In most cases, this was sufficient to restore order.

In some cases, the carotid hold was applied to persons who were handcuffed and in the rear seat of the police car. In those cases, the person was violently kicking the doors and windows of the car in an attempt to escape. The hold was used to subdue the person to allow the legs to be restrained. Such application was not consistent with the Police Bureau's policy on use of the carotid hold.

Most incidents in which the carotid hold was used involved domestic quarrels where no weapon, except hands or feet, was involved and the participants were under the influence of alcohol or drugs or suffered from some sort of mental or emotional disturbance.

The carotid control technique is included in the Police Bureau's training program of defensive tactics. The carotid control instruction begins with a review of the six levels of control. They are: 1) officer presence; 2) vocal control; 3) physical control; 4) serious physical control (carotid control); 5) impact weapons (baton - commonly known as "night-stick") and chemical agents (mace); and 6) deadly weapons.

During the initial four hours of training, officers are made aware of the physiological risks involving the use of the technique. Officers are advised as to how, why and when such injuries may occur and how to prevent, as much as possible,

any injuries to the subject. Each course stresses what they must be aware of and what actions they must take after applying the carotid hold. For example, officers are taught that upon completing the handcuffing procedure, the officer must immediately check the suspect's pulse (first radial and, if not located, then carotid). If no pulse is detectable, the officer must remove the handcuffs, and perform CPR.

Concerning the effects of the hold, the officers are told:

1) Carotid constriction diminishes or stops the flow of oxygenated blood to the brain cells. It takes between 5 to 15 seconds to render the average person unconscious with a properly applied carotid constriction. A person under the influence of alcohol or drugs may become unconscious in less than five seconds. The officer should be aware that massaging the nerves in the carotid sinus can reduce heart rate and blood pressure (this can be an alternative to carotid constriction).

2) The suspect being controlled with carotid constriction may react like a person having a seizure. The eyes may roll back, the body may quiver, and the muscles may relax prior to loss of consciousness. Loss of consciousness (which may be sudden) is likely to occur.

3) The amount of time it takes for a suspect to recover will vary, but it usually takes 20 to 30 seconds. When the suspect regains consciousness, he will be in a confused state for a short period of time (two to ten minutes). He probably will not recall what happened. The suspect's reaction, however, may vary according to other physical factors such as drugs or alcohol.

All officers are then trained to physically apply the hold. The officer is told to apply the hold by applying pressure against the sides of the suspect's neck with his or her bicep and forearm in a scissoring manner. Officers are also taught to never apply carotid constriction while standing. This is taught to eliminate possible injuries to the suspect and officer when the person loses consciousness and falls.

A written evaluation and a physical demonstration are required prior to the officer being certified. The officers are recertified every two years and view a refresher tape every year.

Cardio-pulmonary resuscitation (CPR) is also taught to members of the Police Bureau. All officers are certified annually in accordance with the standards set forth by the American Heart Association and the Red Cross.

Officers are taught to apply the prescribed sequence of CPR steps if a person rendered unconscious by the carotid hold fails to regain consciousness in 20 to 30 seconds.

The Committee heard presentations by four doctors regarding the medical factors involved with the carotid "sleeper" hold.[1] A properly applied carotid hold restricts blood flow to the brain which results in a loss of consciousness. The trachea is not compressed thereby allowing continual flow of oxygen to the subject. The vagus nerve is compressed and/or massaged during the constriction. Constriction or massage of the vagus nerve can result in the slow down, or even stoppage, of the heart[2]. While there was no agreement on why some applications

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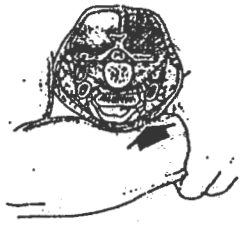
[1] "Death From Law Enforcement Neck Holds", Donald T. Reay, M.D., John W. Eisele, M.D.; The American Journal of Forensic Medicine and Pathology, Vol. 3, No. 3, September, 1982.

Compression of the carotid arteries with preservation of the airway during application of the carotid hold.



Forearm collapses the airway in the choke hold. Small arrow identifies typical site of fracture by this hold.

[2] Ibid.

of the carotid hold are fatal, all the doctors agreed that certain factors increased the risk of fatal consequences. These factors could not reliably be detected by the officers, prior to application of the hold.

They also indicated there is a possibility that application of the carotid hold could result in an unintentional application of a bar arm "choke" hold in which the trachea is compressed and damage could result to the airway, larynx, and surrounding tissue.[3] During the struggle, the officer's arm could move out of position and place pressure to the front of the neck, instead of laterally compressing the sides of the neck.

Another article advanced the theory that the deaths may be related to a phenomenon called acute exhaustive mania.[4] This article contends that the deaths were due to psychological factors rather than physiological factors.

Much attention has been drawn to the deaths associated with the carotid hold across the nation. The incidence of death in comparison to the number of arrests and number of times the hold was used is small. The greatest number of deaths

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[3] Ibid.

[4] "Deaths In Custody Related to Subject Control Tactics: Use of the Neck Restraint", Bruce K. Siddle, Dr. Elizabeth Lapasota, Copyright C 1985.

occurred in the Los Angeles area. A review of those cases revealed that cario-pulmonary resuscitation efforts were either never attempted or were started after several minutes of unconsciousness had elapsed.

In addition to the physical and medical factors involved with the carotid hold, the Committee also reviewed the legal factors facing the City, the Chief, and the officers.

A police officer may be subject to legal liability for intentional or negligent use of excessive force. A civil suit may be filed by an aggrieved citizen or criminal charges may be brought by the grand jury. Further, the police agency may be subject to civil liability if it is negligent in hiring, training, supervision, retention, and assignment, if these are established as a custom, practice or policy of that agency and if they cause the use of excessive force by an officer.

A civil litigant may pursue either federal or state law claims for damages. Under federal law, the claimant may also seek injunctive relief that would ban the continuance of a particular practice or procedure. Federal law also allows awards for punitive damages and attorney fees and there is no limit on the amount of compensatory (actual) damages that may be recovered. A claimant may pursue both federal and state claims in a single action.

The test of excessive force in a civil case is the reasonableness of the force used under all of the circumstances. No more precise definition is available. The officer may also raise certain defenses to such a claim. No Oregon cases have dealt specifically with the carotid hold. Some cases in other jurisdictions have allowed recovery for the use of the carotid; others have not.

In civil cases, involving claims of excessive force, evidence may be presented in an effort to depict the circumstances of the officer's job, his training, the purpose of the arrest, the need for the force, the extent of the injury, misconduct by the claimant and justification for the use of force under the circumstances. Ultimately, a court or a jury composed of citizens of the community will decide whether the use of the carotid hold or any other use of force was reasonable. They could render a verdict for the officer and agency, or returning a substantial verdict against the officer and the agency, depending on their view of the circumstances.

An officer could also face criminal prosecution for the use of the carotid hold if the hold was found not to be justified as reasonably necessary to defend the officer or others. Criminal liability would turn on whether the court or jury defined the carotid hold as physical force or deadly physical force. An officer may use physical force to defend a person, property,

or to make an arrest or prevent an escape. (ORS 161.209; 161.225 and 161.235.) The officer may use the degree of force reasonably necessary to accomplish this purpose. Under some more limited circumstances an officer may use "deadly physical force." (See ORS 161.225 and ORS 161.239.[5]) Deadly physical force is defined as "physical force that under the circumstances in which it is used is readily capable of causing death or serious physical injury." ORS 161.015(3). The Bureau presently does not classify the carotid as deadly physical force. Deadly physical force is the same category in which a firearm may be used by the officer.

There are no Oregon cases deciding specifically whether or not the carotid hold constitutes deadly physical force. Examining many of the same factors as set out above for civil case, a jury would have to decide in each individual case whether or not the carotid is deadly force and then apply the appropriate statutory standards. Depending on this determination by the jury, an officer could be convicted of some level of assault or homicide.

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[5] In the recent case of Tennessee v. Garner, 53 LW 4410 (1985), the United States Supreme Court has examined the law regulating the use of deadly physical force in making arrests. In light of these recent changes, the Portland Police Bureau's legal advisor has reviewed the current Bureau policy on deadly physical force (which was more stringent than the previous legal standard) to ensure that the policy is in compliance with these new standards.

These standards and procedures would apply regardless of the type of physical force the officer uses. No procedures would eliminate the possibility of all law suits. Expense will be incurred in the defense of these suits even though ultimately the claimant recovers no money.

After researching over thirty-five articles, medical surveys, and public opinions, a difference in police departments carotid hold policy is seen. The upper body control hold philosophies of eleven cities of comparable size to Portland confirm this fact - two of eleven police departments permit the use of the carotid hold restraint technique (Long Beach, Oakland); three of eleven police departments prohibit the use of any neck restraint technique (Atlanta, Cincinnati, Minneapolis) and six of eleven police departments have policy that does not specifically address neck restraints, therefore, they are permitted as necessary force (El Paso, Pittsburgh, Tulsa, Buffalo, Miami, Austin). In addition to Long Beach and Oakland, cities that ban the carotid hold completely include Boston, St. Louis, Seattle, Cleveland, Jersey City and Detroit.

Many cities, including Chicago, who permit the carotid hold have implemented the "Kansas City Neck Restraint Program" developed by James Lindell, physical training supervisor of

the Kansas City Regional Training Academy. It gives officers extensive formal training in every aspect of applying the carotid hold, from various positions in which it can be applied, to post-hold care of the unconscious suspect.

The Los Angeles Police Department has experienced more controversy on the carotid than any other police department. Fifteen people have died since 1975 as a consequence of neck restraints used during altercations within the LAPD, according to attorney Michael Mitchell, who has taken his fight to get the LAPD to stop using the controversial holds all the way to the Supreme Court. Mitchell, along with other carotid hold critics, maintain that the LAPD guidelines regarding use of upper body control holds must be changed and clarified. The critics contend the holds should be limited only to situations when the officer faces "serious bodily injury or death."

The above policy is similar to policies already adopted by the New York City, Berkeley, San Francisco, San Jose, Glendale, Phoenix and Houston Police Departments, among others. A major reason for the relatively low number of deaths in cities which allow carotid holds, police officials say, is that those cities prohibited the use of the bar arm control hold as it has been in Los Angeles.

Los Angeles Police Chief Daryl F. Gates enacted limitations

on the use of upper body control holds. These holds are authorized when 1) lower levels of force are either inappropriate, have been exhausted, or are unavailable; and 2) higher levels of force are inappropriate; and 3) when it is necessary to control a suspect who is sufficiently combative that there is a reasonable prospect of bodily injury to officers or others; or when it is necessary to prevent escape; or when tactical considerations of safety to the officer or suspect dictate the necessity for use.

The citizen councils formed seemed to differ widely with police on policy recommendations. Most citizen groups, such as the Hispanic Advisory Council on use of the chokehold by the LAPD, feel that the carotid hold is far too dangerous to use. Citizens as well as police need to be well informed on all aspects of the carotid hold - not just the outcomes.

TRAINING ALTERNATIVES

The Committee believes that officer and citizen safety, as well as police-community cooperation can be increased by providing alternatives to the use of force. Three areas in which alternatives exist are in training, physical conditioning and weaponry.

Training should develop an emphasis on non-violent conflict resolution which can provide the skills to defuse situations rather than cause or allow them to escalate. This training must

range through the full spectrum of interpersonal contact from one on one to Emergency Response Team tactics in handling barricaded person incidents.

While not wishing to minimize the hazards inherent in policing, the Committee believes there should be a realistic balance in assessing the actual potential for danger and not train officers to develop an urban warfare mind-set in dealing with the whole public at large.

It is axiomatic that stereotypical thinking will cause a person to treat another as it is thought he or she will act and thereby tend to cause the very behavior which was sub-consciously predicted. In other words, if you treat someone like a troublemaker because you think he/she is, you will probably have trouble with him/her, and this must be both understood and avoided in routine public contacts, especially so with citizens whose race and background may be different from the officer involved in the contact.

Besides improving relations with the community to be served, reducing the incidence of confrontation enhances officer safety and provides time to exercise other alternatives to direct action. In tactical responses, containment should be the initial priority and thereafter, time is the ally of the police in developing the least violent means for resolving any situation.

Training should also incorporate human relations skills whereby stereotyping persons by virtue of race, sex, economic status or factors is abandoned in favor of assessing people as individuals encountered in a variety of circumstances. Particularly in relation to cultures that may be quite different from the dominant white middle class strata from which most police officers are recruited, we must develop an understanding awareness of our quite natural differences. The alternative to understanding is often disdain or worse yet, fear and failing to effectively address this basic issue can only heighten police-community tensions.

The Committee heard testimony from its own members concerning the relationship of physical fitness and use of force. Several studies conducted nationally indicate that officers who are physically fit tend to use less force than officers who are not.

Police staff presented the Committee with an overview of the "Wellness Program" scheduled to be implemented Bureau wide in September 1985. The program provides physical and mental/emotional fitness assistance. The curriculum includes weight loss, alcohol, tobacco and drug abuse, as well as stress reduction and traditional physical fitness techniques.

The Committee commends the Bureau for developing the Wellness Program for its officers.

EQUIPMENT ALTERNATIVES

Less lethal technology has not yet developed a replacement for the firearm as the ultimate level of force and may never do so. Accordingly, police must be well-armed and should, incidentally, be better armed than their potential adversaries for that relatively rare occasion when they must rely upon their guns to save their lives. In resolving those normally less than life-threatening daily encounters, the Committee believes that the police should avail themselves of a greater range of less lethal weaponry than they now have available to them. Specifically, we recommend:

1) The PR-24 baton should be adopted for general issue to all uniform personnel who are to be trained for certification in its proper use.

2) The kubotan offers another method of obtaining compliance from a resisting person which is easily applied and it too should be seriously considered for general issue and training.

3) The electric "stun gun" should be appropriately evaluated in a field testing environment to determine its suitability for local adoption.

4) We would encourage evaluation of the auto-loading pistol as a possible replacement for the traditional revolver. This can give the officer a more effective firearm when it is needed but a more difficult weapon to be used against him or her when taken away during a struggle, thereby better protecting officers from being shot with their own gun - a not infrequent tragedy.

5) Other items which the Committee viewed should also be considered for use under special conditions and these included: capture nets, the "immobilizer" (chain and pole device), a rubber baton projector, tear gas and various delivery systems, and stun grenades.

As less lethal technology continues to be refined, the Committee would urge that a commitment to testing such devices be made and where found appropriate, they should be added to an inventory of viable alternatives to deadly force.

LEVELS OF FORCE: RECOMMENDATIONS

It is critical in an urban society that the individual police officer not be expected to personally resolve every situation with which he or she may be confronted. We have long since advanced beyond the frontier days where such precipitous action was either necessary or acceptable. Contemporary policing absolutely requires a depth of response to deal with those unusual occurrences which go beyond routine police contacts. For this purpose, a highly skilled emergency response team with state of the art capabilities in both tactics and technology is essential.

To reach its recommendation, the Committee has carefully balanced community need for effective law enforcement and its interest in protecting individual rights and liabilities of citizens. The best law enforcement is based on cooperation and respect between the police force and the people they serve. The police have a difficult job and must be assisted in every manner possible to ensure they have the necessary tools and training to protect the public without abusing people's rights.

This Committee recommends that the Portland Police Bureau ban the carotid at its present level and elevate it to deadly force. Current policy permitted use of the carotid hold as the fourth level of force out of six. This recommendation places it on the highest level, as with the use of a firearm.

Bureau policy authorizes the use of deadly physical force in a police action only when the officer reasonably believes that the use of such force is necessary to defend the officer or another person from what the officer reasonably believes to be the infliction or threatened infliction of serious physical injury or to apprehend a person who the officer has probable cause to believe has committed a crime involving the infliction or threatened infliction of serious physical injury. These are very serious situations and the officer needs to respond with necessary force. For example, situations where, due to the proximity of other officers or bystanders, discharging a firearm may be inappropriate although otherwise justified. Continued carotid training would maintain proficiency and allow them to gain control expeditiously when necessary.

Additionally, we recommend that the Bureau monitor and gather data about how current incidents are handled, what control techniques are used, and what injuries are incurred for analysis in August 1986.

During this time, the Bureau should emphasize training techniques which reduce the risk of physical confrontation (see page 20). The Bureau should also examine other jurisdictions and seek methods for improving the safety of the carotid.

ADDITIONAL RECOMMENDATIONS

Although not a specific charge to the Committee, we feel we would be remiss if we did not offer further suggestions for closing the apparent communications gap between the community and their police, wherein both at least partly perceive themselves to be alienated from each other. That problem can only be ameliorated by opening the communication process so that greater mutual understanding can evolve through dialogue - mutual respect will follow. Toward that goal, the Committee recommends:

1) Cultural awareness and human relations training should be given priority emphasis as already explained earlier in this report. People are slow to change their beliefs, however, and expectations of what behavior is acceptable must be clearly defined and then enforced until attitudes come into conformance with standards.

2) An aggressive minority recruitment program must be designed and implemented so as to make the police truly representative of the whole community whom they serve. The importance

of this commitment cannot be over-stressed as a means to improve cultural awareness, reduce stereotyping by providing demonstrable exceptions to such thinking within the organization itself, identify intentional or unintentional incidents of biased behavior, and give minority citizens a sense of being included in, rather than excluded from, the forces that police their neighborhoods.

3) Increased non-controlling contact between the community and their police must be initiated to replace a seemingly existing "them versus us" syndrome with a new partnership. Crime is not just a police problem, it is a community problem and if progress is to be made in achieving our mutual goal of increased public safety, we must work together!

A variety of opportunities exist for fostering this partnership. Officers could become more involved in community activities through such activities as big brother/sister programs, sponsoring and coaching youth athletic teams, increased involvement with boy scout and girl scout troops, promoting and assisting in the conduct of junior and/or handicapped olympics.

The Police Bureau and the community should recognize and reward those officers who give that extra effort to their community.

This interpersonal contact of a helping nature will create a positive relationship between the parties which can foster a whole new perception of one another and, besides, it enriches the officers' otherwise mostly negative job!

4) To build greater public confidence, the internal investigation process should be as open to public scrutiny as is consistent with its purpose and especially scrupulous in its inquiries, while always mindful of the officers' rights and ensuring that their day-to-day performance is not compromised.

5) In contrast to the picture often painted by movies, T.V., and media, officers most often are called to situations in which people are "out of control"; that is, under the influence of drugs, alcohol, experiencing mental problems and/or involved in a disagreement of some kind. The U.S. Dept. of Justice[6] estimated that in 1978 at the time of

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[6]"Profile of Jail Inmates - Sociodemographic Findings from the 1978 Survey of Inmates of Local Jails", U.S. Dept. of Justice, October, 1980.

arrest, roughly 20% of convicted persons were under the influence of drugs at the time the crime was committed, and 28% had consumed heavy amounts of alcoholic beverages (8 cans of beer or 9 oz. of liquor). An additional 16% had consumed smaller amounts of alcohol. In 1983, 20% of all the people taken into custody by the Portland Police were treated at the Hooper Memorial Detoxification Center because they were unable to care for themselves due to alcohol or drugs. Eighteen percent of all persons taken into custody were charged with Driving Under the Influence of Intoxicants, Liquor Law Violations, or Drug Law Violations.

At least 47% of all the situations involving use of the carotid hold, baton and chemical mace in 1983-84 involved people under the influence of alcohol or drugs, or who suffered from mental disorders.

Community responsibility to educate our children and young adults by providing direct information regarding substance abuse, as well as helping create employment, education and recreational opportunities for all our citizens has been suggested in many other forums, but we repeat it here.

Daily combat with people who are "out of control" reinforces an urban warfare mindset. Survival becomes the sole issue. "Us versus them" becomes a reality. To ensure the officers we have asked to protect us are protected themselves, we must attack the root of the problem. Alcohol and drug abuse are not just police concerns, but community concerns. Only we, the police and community together, can bring peace to our streets.

SUMMARY OF FINDINGS AND RECOMMENDATIONS OF THE FINAL REPORT AND RECOMMENDATIONS OF THE COMMITTEE ON POLICE USE OF FORCE.

The following summary of the Police Use of Force Committee Report represents the unanimous findings of the Committee.

1. Training should incorporate human relations skills and cultural awareness. (p. 22)

2. The Committee commends the "Wellness Program" scheduled to be implemented Bureau wide in September 1985, providing physical and mental fitness assistance. (p. 22)

3. The PR-24 baton should be adopted for general issue to all uniform personnel who are to be trained for certification in its proper use. (p. 23)

4. The kubotan offers another method of obtaining compliance from a resisting person which is easily applied and it too should be seriously considered for general issue and training. (p. 23)

5. The electric "stun gun" should be appropriately evaluated in a field testing environment to determine its suitability for local adoption. (p. 24)

6. We would encourage evaluation of the auto-loading pistol as a possible replacement for the traditional revolver. This can give the officer a more effective firearm when it is needed but a more difficult weapon to be used against the officer when taken away during a struggle, thereby better protecting officers from being shot with their own gun - a not infrequent tragedy. (p. 24)

7. We recommend that the Portland Police Bureau ban the carotid at its present level and elevate it to deadly force. This recommendation places it on the highest level, as with the use of a firearm. (p. 25)

8. We recommend that the Portland Police Bureau monitor and gather data for one year about how incidents involving serious physical force are handled, what control techniques are used and what injuries are incurred for analysis by August 1986. (p. 26)

9. An aggressive minority recruitment program must be designed and implemented so as to make the police truly representative of the whole community whom they serve. (p. 27)

10. Increased informal contact between the community and their police must be initiated to replace a seemingly existing "them versus us" syndrome with a new partnership. (p. 28)

11. To build greater public confidence, the internal investigation process should be as open to public scrutiny as is consistent with its purpose and especially scrupulous in its inquiries, while always mindful of the officers' rights and ensuring that their day-to-day performance is not compromised. (p. 29)

12. The high percentage of contacts and arrests which involve people who are "out of control" due to alcohol, drugs or mental problems require community response. Only we, the police and community together, can bring peace to our streets. (p. 29-31)

Submitted to Portland Police Chief Penny E. Harrington
on July 18, 1985

APPENDICES

APPENDIX A

COMMITTEE ON POLICE USE OF FORCE

Date	Speaker
5-9-85	Captain Inman, PPB Training Staff Officer Ken Gardner, PPB Training Staff Officer Aaron Harvey, PPB Training Staff Sgt. Bruce Prunk, PPB Training Staff Officer Mark Fortner, PPB Training Staff Sgt. Archie Fortner, PPB Training Staff Lt. Alan Orr, PPB Training Staff
5-15-85	Chief Atkins Warren, National Administration of Justice Specialist, U.S. Department of Justice
5-23-85	Lt. Tim Johnson, Bellevue PD Training Unit Officer Jack McDonald, Bellevue PD Training Unit Officer Gary Manougian, Portland Police Bureau Officer Bob Johnson, Portland Police Bureau Officer Greg Igo, Portland Police Bureau
5-30-85	Dr. Donald Reay, King County Medical Examiner Dr. Larry Lewman, Multnomah County Medical Examiner Dr. Alan Ames, Good Samaritan Hospital Dr. Dick Banner, Cardiologist
6-6-86	Stan Peters, President, Portland Police Association Sgt. Bob Baxter, Portland Police Bureau Lt. Gary Schrader, Portland Police Bureau
7-10-85	Kathleen Payne-Pruitt, Multnomah County District Attorney's Office Doug Andres, Bullivant, Houser, Bailey, Pendergrass, Hoffman, O'Connell & Goyak, Attorneys Anna Brown, Bullivant, Houser, Bailey, Pendergrass, Hoffman, O'Connell & Goyak, Attorneys

APPENDIX A

COMMITTEE ON POLICE USE OF FORCE

LETTERS RECEIVED

Mrs. Joan Synarski
4059 N. Overlook Terrace
Portland, OR 97227

Ned & Faith Stafford
3844 NE Alameda
Portland, OR 97212

Bill Wheeler
930 SE 31st Ave.
Portland, OR 97214

John Blank
Human Relations Specialist
Metropolitan Human Relations Commission
1120 SW Fifth, Room 520
Portland, OR 97204

Francis Bailey
1715 Dorothy Ave.
Longview, WA 98632

John Hawkins

E.J. Chalmers

Tom Warren

Dr. Bong W. To
Chinese Social Service Center

APPENDIX B

COMMITTEE ON POLICE USE OF FORCE

PUBLIC FORUM SPEAKERS

1. Bob Portwood, Woodlawn Improvement Association
2. Merritt Yoelin, American Jewish Committee
3. Roger Auerbach, Jewish Federation of Portland
   (read by Merritt Yoelin)
4. Adrienne Weller, Radical Women
5. Joan Synarski
6. Lucinda Cannard
7. Faye Bell
8. Vesia Loving
9. Yolanda Dials
10. Sam Hooson
11. Gil Veyna
12. Jeanne Fryer

APPENDIX C

LAPD USE OF FORCE STUDY

Reviews policy, procedure, and training relating to neck holds (bar arm, carotid, modified carotid, locked carotid, chancery and front headlock), baton, chemical agents, and Taser electronic control device.

Neck holds were used in .26% of all arrests. Death resulted in .0008% of all arrests and .3% of those arrests where the hold was used.

Recommends retaining carotid hold.

LAPD POSITION STATEMENT ON LIMITATIONS TO THE USE OF UPPER BODY CONTROL HOLDS

The control holds are authorized when:

1. Lower levels of force are either inappropriate, have been exhausted, or are unavailable; and

2. Higher levels of force are inappropriate; and

3. Any of the following circumstances apply:

    a. when it is necessary to control a suspect who is sufficiently combative that there is a reasonable prospect of bodily injury to officers or others; or

    b. when it is necessary to prevent escape; or

    c. when tactical considerations of safety to the officer or suspect dictate the necessity for use.

All use of force to be reviewed by the Chairman of the Use of Force Review Board for compliance to policy and appropriateness of tactics involved.

STATEMENT OF LAPD ON USE OF UPPER BODY CONTROL HOLDS RELEASED
5-6-82

Withdraws authorization for use of the bar arm control hold and limits use of carotid control hold to same provisions as outlined in previous statement.

Describes lower levels of force as verbalization, firm grip control, pain compliance holds and possible use of chemical agents.

Describes higher levels of force as use of police baton, various karate kicks and use of deadly force, i.e., firearms.

Increased utilization of the TASER device has been ordered due to effectiveness as a control device.

Orders re-study of the SWARM technique.

Establishes a Doctor's Consortium to advise on medical aspects relating to the use of existing control techniques and to advise on the development of future techniques.

STANDARDS FOR LAW ENFORCEMENT AGENCIES

Commission on Accreditation for Law Enforcement Agencies, Inc.
1983

Chapter 1 - Law Enforcement Role and Authority Standards for Accreditation

"MEDICAL IMPLICATIONS OF NECK RESTRAINTS - A NEW LOOK" by Dr. James Cooper, Chief Surgeon (Vascular), DePaul Hospital, St. Louis, MO

Describes medical effects of application of neck restraint systems.

"DEATHS IN CUSTODY RELATED TO SUBJECT CONTROL TACTICS: USE OF THE NECK RESTRAINT" by Bruce K. Siddle, Physical Training Coordinator, Kansas City Police Department and Dr. Elizabeth Lapasota, Research Forensic Pathologist, Barnes Hospital, St. Louis, MO

Research paper dealing with unexplained custody deaths. Describes deaths following use of neck restraints and physical restraint of individuals in custody. Describes a phenomenon in which psychiatric patients in a manic combative state died after being restrained. Often times, the restraint involved no more than holding the subject down by the arms and legs. Also eludes to death due to cocaine psychosis.

"POLICE NECK RESTRAINTS - AT THE CROSSROADS" by Major Charles E. Braden and James W. Lindell, Kansas City Police Department, Kansas City, MO

Discussion of rationale to retain use of neck restraint systems for law enforcement use.

USE OF FORCE POLICIES AND PROCEDURES

Pittsburgh, PA	6-1-82
Austin, TX	6-20-80
Oakland, CA	4-19-82
El Paso, TX	Date Unknown
Santa Fe, NM	Date Unknown
San Diego, CA	Date Unknown

Summary of eleven cities of comparable size to Portland, OR.

CITY OF LOS ANGELES

Stipulation of facts surrounding the deaths of sixteen people following application of neck restraint holds between 1975 and 1982, dated May 21, 1985.

Press release regarding death of subject subdued with a TASER, dated April 15, 1985.

PROFILE OF JAIL INMATES

National Prisoner Statistics Report, SD-NPS-J-6, NCJ-65412, October 1980, U.S. Government Printing Office, Washington, D.C.

This report is an overview of the demographic and socioeconomic characteristics of inmates held in the Nation's local jails. Basic findings on the use of drugs and alcohol are also presented. It is the first in a series based on the 1978 Survey of Inmates of Local Jails to be published by the Bureau of Justice Statistics. Reports dealing with the inmates' experience with the adjudication process and bail, a detailed examination of drug and alcohol usage, and other specialized topics will be included in the series.

PERIODICALS

THE POLICE CHIEF

November, 1978 - Alice McGrath, expert choke hold and carotid hold. Choke - high risk of fatility tactic. Carotid - low risk of serious injury technique. Policy and training are critical for reducing hazard of unintentional death.

March, 1985 - WORKSHOP - Medical/Legal Analysis of Use of Force, Jim Lindell, Physical Training Instructor, Kansas City Police Department, Kansis City, MO

Discussion of Kansas City Police Department Lateral Vascular Neck Restraint System and the Nerve Pressure Point System. Similar to Portland Police Bureau carotid control technique. Control without rendering subject unconscious is preferred technique. Complete loss of consciousness, however, is part of system. Neck Restraint and Pressure Point System have been integrated to give officers enhanced control technique. System has been used 14 years with no resulting litigation.

THE AMERICAN JOURNAL OF FORENSIC MEDICINE AND PATHOLOGY

Vol. 3, No. 3, September, 1982 - Pathological description of choke hold and carotid hold. Potentially lethal under any circumstance. Use only when there is no other alternative. Identifies five conditions in which the risk of neck holds increases. Emphasizes importance of proper training.

JUDO USA

Vol. 4, No. 2 1978 - Physiological Effect of Shime-waza by Ron Lappage

Reports on a study conducted by Leo Marinier (Nidan), University of Victoria, in which high frequency sound waves were used to detect blood flow during application of carotid hold.

Concluded that such holds could be deadly for people with heart disease.
(Furnished by Gregg McMurray)

PERIODICALS (continued)

FBI LAW ENFORCEMENT BULLETIN

August, 1984 - State and Local Law Enforcement Training Needs by Robert G. Phillips, Jr.

FBI study of training needs and priorities within law enforcement agencies. Fifty-four priorities were listed for all agencies. Firing weapons for practice/qualification ranked 25; control individuals placed under arrest ranked 29; administer first aid ranked 41.

January, 1985 - Police in a Violent Society by John G. Stratton, Ph.D.; John R. Snibbe, Ph.D.; Lt. Kenneth Bayless, Los Angeles County Sheriff's Department.

Overview of advantages, disadvantages of several non-lethal control devices, public perception and police use of force.

POLICE MAGAZINE

July, 1982 - Hanging Men by George R. MacLarty
Short story detailing the bizarre tragedies encountered by police officers and others who respond to violent and/or life threatening situations. The story illustrates the defense mechanism employed through humor which allows such responders to cope with the psychological trauma they encounter on a daily basis.

OREGON POLICE CHIEF

Winter, 1985 - Officers Slain
Article indicating that of 35 law enforcement officers killed in the first half of 1984, 30 were killed with firearms, 2 were stabbed or cut, 1 was run down by a vehicle, a 2 were killed by blows from hands, fists, or feet. This represents that almost 6% of the deaths were not due to use of a weapon.

PERIODICALS (continued)

LAW AND ORDER MAGAZINE

June, 1985 - Electronic Weaponry, The Pros and Cons by Jim Halloran

Discussion of positive and negative effects of electronic weapons. Positive and negative statements of agencies using or considering use of such weapons.

SEATTLE TIMES

1-22-83 - Explanation arm bar and carotid hold based on report by Dr. Donald Reay and Dr. John Eisele, Medical Examiner's Office.

SEATTLE POST INTELLIGENCER

4-12-83 - King County jail limits use of neck hold to "immediate threat" to a guard or another person. Seattle City Council recommends ban on neck holds in King County Jail.

4-7-83 - Bellevue Police Chief Donald Van Blaricom called for State law banning use of deadly force by law enforcement officers unless the officer or another person's life is in danger. Also characterizes the use of neck holds as deadly force.

3-27-83 - Inadequate guard training in application of carotid hold contributed to choke hold death.

3-21-83 - Criminal negligence found by King County inquest in choke hold death of jail inmate. A "John Doe" responsible for the jail policies was also criminally negligent.

LOS ANGELES TIMES

3-12-83 - Bill introduced in California Legislature to ban choke hold and limit carotid hold to lethal force situations.

12-28-82 - Editorial by Los Angeles City Council member calling for ban on the choke hold.

L. A. HERALD EXAMINER

4-26-82 - Summarizes case histories of 15 alleged choke hold victims.

Summarizes survey by Herald Examiner of 19 police departments that use neck holds. Twelve of 19 do not teach choke hold.

THE DALLAS MORNING NEWS

5-3-85 - Death of 23-year old arrested by police, result of "cardio-respiratory arrest due to a chokehold."

Inquiry into second police related death is pending.

Police department creates policy making carotid restraint "as a next-to-last resort"..."just before you shoot somebody."

THE SKANNER

5-15-85 - "Black Faces Mirror Turmoil"
Charles W. Faulkner, Ed.D., Director of the Center for Attitudinal Studies, Washington, D.C.

Article indicates a perception of combativeness and hostility in the expressions of many Blacks. Author believes this is a projection of tension, turmoil, anxiety and unhappiness. He states it is compounded by Black's great misconceptions about whites that guide their behavior.

THE DALLES WEEKLY REMINDER

5-16-85 - Don't Choke 'Em, Smoke 'Em T-Shirts Stupid, But Human
Editorial indicating T-shirts were expression of psychological safety valve used by various professionals to cope with stress. Admonishment to consider the statement as poor taste, but human.

PORTLAND POLICE BUREAU

Carotid Control Survey - 5-7-85
Telephonic survey of thirty-one (31) police agencies in Oregon, Washington and California regarding their use and policies regarding carotid hold.

The majority use the hold. A minority experienced deaths or injuries. Only one agency which now prohibits use of the hold had permitted its use previously.

Legal Opinion - 9-24-84
Use of control technique which could have caused death is not "use of deadly force" if in fact no death or serious physical injury occurred.

The line between justification for use of force versus use of deadly force is dependent on the wording in the officer's report.

Arrest/Use of Force Information - 5-9-85
Summary by race for 1984 of officers, suspects, arrests, resist arrest, assault on a police officer and type of force used.

Carotid Hold Use - 1984
Summary of type of incident, force used by suspect, carotid pressure applied, loss of consciousness, pulse check, carotid applied after cuffing, injury to suspect, and injury to officer.

Assaulted Office Summary - 1984
Summary by activity, number of officers, weapons, month, day of week, time of day, demographics of offender, and demographics of officers involved.

CRIME REPORT - 5-15-85 - Bigelow, William J.
Example of arrest situation in which use of physical restraint was ineffective. Injury to officer. Baton not used.

Inter-Office Memorandum - 2-1-85 - Acting Captain Alan Orr, Training Division
Review and comment on three use of force situations. Feedback on recommendations made in supervisory review.

Baton Use - 1984
Summary of type of incident, force used by suspect, injury to suspect, and injury to officer.

Inter-Office Memorandum - 5-22-85 - Officer Bigeagle, North Precinct
Report of incident in which carotid hold would normally have been used. Subject subdued through use of baton by two officers.

Inter-Office Memorandum - 6-27-85 - Mary Overgaard, Legal Advisor
Review of Portland Police Bureau Use of Deadly Force Policy for compliance with Tennessee vs. Garner decision.

Use of Force Comparison
4-19-84 through 6-23-84 and 4-19-85 through 6-23-85

Contrasts injury rates to Portland Police Bureau officers in resist arrest cases for two month period before and after the carotid ban.

APPENDIX D

1984

TYPE OF INCIDENT

Selling Stolen Property	1
Assault	5
Interfere with Police Officer	5
Car Prowl	2
Unwanted	4
Theft	2
Family Disturbance	13
Disturbance	6
DUII	1
Attempted Suicide	1
Runaway	1
Mental	3
Traffic Stop	1
Wanted Subject	1
Loud Stereo	1
Vandalism	1
Prostitution	2
TOTAL	50

1984

FORCE USED BY SUSPECT

Hands, Fist, Feet, Body	47
Knife	1
Razor Blade	1
Teeth	1
Fingernails	2
Pitchfork	1
Baseball Bat	1
Lamp	1
Machete	1
Crutch	1
Police Baton	1
TOTAL	58*

* This total reflects more than one type of force used in some instances.

POPULATION TO ARREST RATIO - 1984

Population	Race	Ratio
366,383		11.13:1
10,625	A*	46.20:1
28,211	B	3.28:1
7,694	H	6.10:1
3,663	I	3.42:1
316,190	W	14.57:1

ARRESTS TO USE OF FORCE RATIO - 1984

	Arrests	Carotid	Baton	Hair	Mace
A	96	N/A	N/A	N/A	N/A
B	8,603	318.6:1	1720.6:1	2150.8:1	8603:1
C	21	N/A	N/A	N/A	N/A
H	1,262	1262:1	1262:1	N/A	N/A
I	1,071	535.5:1	535.5:1	1071:1	N/A
J	14	N/A	N/A	N/A	N/A
U	42	N/A	N/A	N/A	N/A
V	99	N/A	N/A	N/A	N/A
W	21,699	350:1	904.1:1	1205.5:1	N/A
TOTAL	32,907	530.8:1	1371.1:1	1828.2:1	32907:1

1984

INJURY TO OFFICER

None	35	
Abrasions	4	
Broken Hand	2	1 before hold was applied
Broken Nose	2	Both before hold was applied
Cut	4	During altercation
Bruises	2	During altercation
Blood in Urine	1	Result of altercation
Bloody Nose	1	During altercation
Sprained Wrist	1	During altercation
Sprained Thumb	1	During altercation
TOTAL	53*	

Note: One officer had bruised and swollen ankle due to being struck with police baton.

* This total reflects more than one type of injury or injury to more than one officer in some of the cases.

1984

INJURY TO SUSPECT

	B	W	H	I	TOTAL
None	20	24	1	1	46
Cut Lip		1			1
Cut Forehead		1			1
Bloody Nose		1			1
Chest Pain		1			1
TOTAL	20	28	1	1	50

Note: The following injuries also occurred:

W - Lacerated head from flashlight
W - Bruise from baton
B - Bruise from baton
W - Cut wrists from razor blade in suicide attempt

SUMMARY OF FINDINGS AND RECOMMENDATIONS

1. Training should incorporate human relations skills and cultural awareness. (p. 22)

2. Specifically, the Committee commends the "Wellness Program" scheduled to be implemented Bureau wide in September 1985, providing physical and mental fitness assistance. (p. 22)

3. The PR-24 baton should be adopted for general issue to all uniform personnel who are to be trained for certification in its proper use. (p. 23)

4. The kubotan offers another method of obtaining compliance from a resisting person which is easily applied and it too should be seriously considered for general issue and training. (p. 23)

5. The electric "stun gun" should be appropriately evaluated in a field testing environment to determine its suitability for local adoption. (p. 24)

6. We would encourage evaluation of the auto-loading pistol as a possible replacement for the traditional revolver. This can give the officer a more effective firearm when it is needed but a more difficult weapon to be used against

12. The high percentage of contacts and arrests which involve people who are "out of control" due to alcohol, drugs or mental problems require community response. Only we, the police and community together, can bring peace to our streets.

1984

CAROTID PRESSURE APPLIED

	B	W	H	I	TOTAL
Yes	18	23	1	1	43
No	2	3			5
Unknown	_	2	_	_	2
TOTAL	20	28	1	1	50

1984

LOSS OF CONSCIOUSNESS

	B	W	H	I	TOTAL
Yes	4	4	1		9
No	8	20		1	29
Unknown	8	4	_	_	12
TOTAL	20	28	1	1	50

1984

PULSE CHECK

	B	W	H	I	TOTAL
Yes	2	1			3
No	9	16		1	26
Unknown	9	11	1	—	21
TOTAL	20	28	1	1	50

1984

CAROTID APPLIED AFTER CUFFING

	B	W	H	I	TOTAL
Yes		2			2
No					
Unknown	—	—	—	—	—
TOTAL		2			2