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Date: 16th July 2020

Our Reference: FOIA-2020-073

RE: Your request for information under the Freedom of Information Act 2000

I write in response to your Freedom of Information Act 2000 (FoIA) request dated **19/06/2020**, in which you requested:

Please provide all information held by the College:

1. On repeat-Tasering and Tasering someone for a longer period than the recommended 5-seconds, as well as the increased risk of injury in regards to repeat-Tasering and Tasering for longer than 5 seconds.
2. On whether a medical examination by ambulance or hospital staff is required if someone is Tasered more than once, or for longer than 5 seconds.
3. In regards to advice for police in using Tasers on 'drive-stun' mode and occasions when is it acceptable. In addition, information held in relation to the fact that in some cases, the Taser loses its incapacitating effect and can further stimulate resistance.
4. On whether officers complete the basic Taser training in their own police forces and if so, who is responsible for setting the training standards. Furthermore, what measures are taken to ensure that the training is uniform in all forces.
5. In relation to how officers are trained to recognise indicators of mental illness and how they are taught to take this into consideration when dealing with the subject
6. In relation to whether any new guidelines or regulations been introduced in the training following the inquest into Marc Cole's death.

On 23/06, you provided clarification that for questions 1-5, only the current training materials and guidance were required.

On 25/06, you provided clarification that for question 5, only information relating to the most basic Taser training (the mandatory 18-hours), was required.

Decision

When a request for information is made under the FoIA 2000, a public authority has a general duty under section 1(1) of the Act to inform an applicant whether the requested information is held. There is then a general obligation to communicate that information to the applicant. If a public authority decides that the information should not be disclosed because an exemption applies, it must, under section 17(1) cite the appropriate section or exemption of the Act and provide an explanation for relying upon it.

Under section 1(1), I can confirm the College holds **some recorded information** within the scope of your request.

There are also a number of publicly available Authorised Professional Practice (APP) documents which may be relevant to your request, I have provided hyperlinks for these below. APP is developed and owned by the College and can be accessed online. It is authorised by the College as the official source of professional practice on policing. Police officers and staff, including those using Taser, are expected to have regard to APP in discharging their responsibilities.

Each part of your request has been dealt with separately:

1. **On repeat-Tasering and Tasering someone for a longer period than the recommended 5-seconds, as well as the increased risk of injury in regards to repeat-Tasering and Tasering for longer than 5 seconds.**

I can confirm the College holds some information for this part of the request. This is to be provided to you under the title of 'Disclosure document 1'. The document is comprised of extracts from the Taser training curriculum (TTC) and mandatory Taser training course (MTTC).

An exemption under section 31(1) – Law Enforcement has been applied to parts of the disclosure document, allowing some of its content to be redacted. This has been clearly stated on the disclosure document.

Relevant College APP documents:

- Conducted energy devices (Taser) - Use
- Conducted energy devices (Taser) – Risk factors

You also may find these non-College documents of use:

- Scientific Advisory Committee on the Medical Implications of Less-Lethal Weapons (SACMILL)
- Defence Scientific Advisory Council Sub-Committee on the Medical Implications of Less-Lethal Weapons (DOMILL)

2. **On whether a medical examination by ambulance or hospital staff is required if someone is Tasered more than once, or for longer than 5 seconds.**

I can confirm the College holds some information for this part of the request. This has been provided to you in the attachment 'Disclosure document 2', and is comprised of parts from both the TTC and MTTC.

Relevant College APP documents:

- Conducted energy devices (Taser) - Aftercare

3. **In regards to advice for police in using Tasers on 'drive-stun' mode and occasions when is it acceptable. In addition, information held in relation to the fact that in some cases, the Taser loses its incapacitating effect and can further stimulate resistance.**

I can confirm the College holds some information for this part of the request. However, nothing is held on Taser losing its incapacitating effect. The held information can be found in the attachment titled 'Disclosure document 3', made up of relevant information from the MTTC.

Relevant APP documents:

- Conducted energy devices (Taser) – Stun modes
- Conducted energy devices (Taser) - Use

4. **On whether officers complete the basic Taser training in their own police forces and if so, who is responsible for setting the training standards. Furthermore, what measures are taken to ensure that the training is uniform in all forces.**

I can confirm the College holds some recorded information for this part of the request. However, **no information** is held on measures taken by the College to ensure training is uniform in all forces. The information can be found in 'Disclosure document 4', where relevant extracts of the CED Curriculum and Training document have been provided to you.

Some content has been redacted in 'Disclosure document 4', this is **not** because an exemption applies, but because the redacted content is irrelevant to your request.

Relevant APP documents:

- Code of Practice on Armed Policing and Police use of Less Lethal Weapon
- Conducted energy devices (Taser) - Training

5. **In relation to how officers are trained to recognise indicators of mental illness and how they are taught to take this into consideration when dealing with the subject**

I can confirm some information is held for this part of the request. This can be found in 'Disclosure document 5', comprised of extracts from both the TTC and MTTC.

Relevant APP documents:

- Mental health
- Armed deployment – dealing with people

6. **In relation to whether any new guidelines or regulations been introduced in the training following the inquest into Marc Cole's death.**

No recorded information held.

However, for context, the College reviewed the information provided by the Coroner following the inquest into the death Marc Cole. As a conclusion of that that review, it was established that the College's current guidance and learning materials addressed the risks associated with the number and duration of Taser activations. College materials were developed in line, and in close consultation with, the independent body (SACMILL) that advises the Home Office on the medical issues associated with conducted energy devices.

Please find an explanation of the decision to use section 31(1) below; your rights are provided at the bottom of this letter.

Yours sincerely,

Kate Kaufman | Legal Researcher
Legal Services
College of Policing
Email: FOI@college.pnn.police.uk
Website: www.college.police.uk

Section 31(1)(a) – Law Enforcement

As a publicly funded body and from an ethical perspective, the College accepts it has a duty to make appropriate information available to the public wherever possible. We appreciate that there is a public interest in the nature of the Taser training provided by the College, and wherever possible, in order to better inform the public about the work that we do, we aim to publish certain guidance documents. Additionally, we appreciate that spending of public money and a public authority's ability to generate income, are matters of strong public interest.

However, the College must also consider the wider impact of disclosing specific detail about police Taser training. By the very nature of our work, the disclosure of the information requested carries the potential risk of highlighting areas of weakness within police training. The possible disclosure of law enforcement tactics may have a negative impact on law enforcement operations, both in the UK and abroad. This in turn could increase the risk to the safety of the public and indeed law enforcement. Disclosure could hinder the effective prevention and detection of crime as it has the potential to reveal specific tactics the police use.

Disclosure of information that undermines the operational integrity of law enforcement capabilities is highly likely to have an adverse impact on public safety and a negative effect on law enforcement generally. This risk to public safety cannot be said to be in the public interest.
As stated above, the public interest test is a consideration of whether the community benefit of possession of the information outweighs the potential harm of releasing that information. It is not an evaluation of what interests the public. On weighing up the competing interests, I consider that the public interest test favours redacting the tactical detail on use of Taser from Disclosure document 1.

Your right of review

Under the Freedom of Information Act 2000 you have a right to request an internal review if you are dissatisfied with our handling of your request. Review requests should be made in writing (by email or post) within **40 working days** from the date of our original response. We will aim to respond to your review request within **20 working days**.

The Information Commissioner's Office (ICO)

If, after lodging a review request you are still dissatisfied, you may raise the matter with the ICO. For further information you can visit their website at https://ico.org.uk/for-the-public/official-information/. Alternatively, you can contact them by phone or write to them at the following address:

Information Commissioner's Office

Wycliffe House

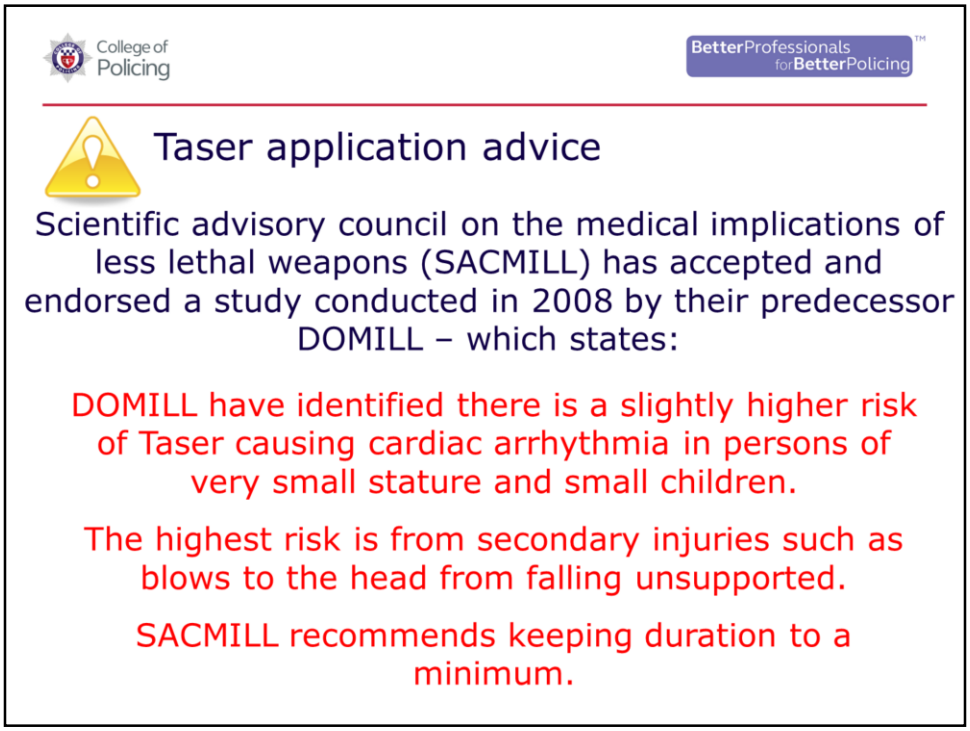
Water Lane

Wilmslow

Cheshire

SK9 5AF

Phone: 0303 123 1113



According to international standards, implantable cardiac devices such as pacemakers and or Implantable Cardioverter Defibrillators (ICDs) must be designed to withstand the output of external defibrillators that function at significantly higher power levels than the TASER devices. If placed in direct contact with a pacemaker, the electrical output could momentarily affect it without health endangerment. See below:

Energy per Pulse

Defibrillators	150 - 400 joules
X26	delivered into load – 0.07 joules

Pacemakers and ICDs are designed to withstand the extremely high energy (360 joule) shocks delivered by external defibrillators. This is required by US federal standards and every pacemaker and ICD model must be shown to be able to withstand the effect of such shocks. (Active Implantable Medical Device requirements 90/385/IEC).

In one case, a person with an implantable device received a five-second probe deployment. Although the implantable device recorded an event, the device charged but no shock was delivered by the implantable device. Haegeli,

Laurent, "*Effect of a TASER shot to the chest of a patient with an implantable defibrillator*" Heart Rhythm Society, 2006. A longer TASER device deployment could temporarily confuse an ICD into thinking that the TASER pulses were a fast heart beat and the ICD might give a shock. There should be no negative impact on the patient or the ICD.

DOMILL:

•**Not known whether there is a risk to the heart from X26 discharges to the frontal chest.**

•**Precautionary approach – assume that there is a risk:**

•**Children and thin adults may be more at risk from discharge through a barb that has penetrated the chest wall overlying the heart – the thinner chest wall means that the barb (and electrical current) will be closer to the heart.**

•**Intoxication with certain recreational drugs and pre-existing heart disease would enhance the risk of induction of serious arrhythmia.**

•**If there is a risk, then this would be mitigated by avoiding shots to the frontal chest over the heart region (if this is tactically achievable).**

•Multiple or prolonged discharges should be avoided.

<u>Cardiac Arrythmia</u>

During an **arrhythmia**, the heart can beat too fast, too slow, or with an irregular rhythm. A heartbeat that is too fast is called tachycardia (TAK-ih-KAR-de-ah). A heartbeat that is too slow is called bradycardia (bray-de-KAR-de-ah). Most **arrhythmias** are harmless, but some can be serious or even life threatening

<u>SACMILL Recommendations</u>

Officers should be cognisant of the increased medical risks associated with repeated or extended applications of Taser and the SACMILL recommendation that exposure duration should be minimised.

All redactions below are under section 31(1) Law enforcement.

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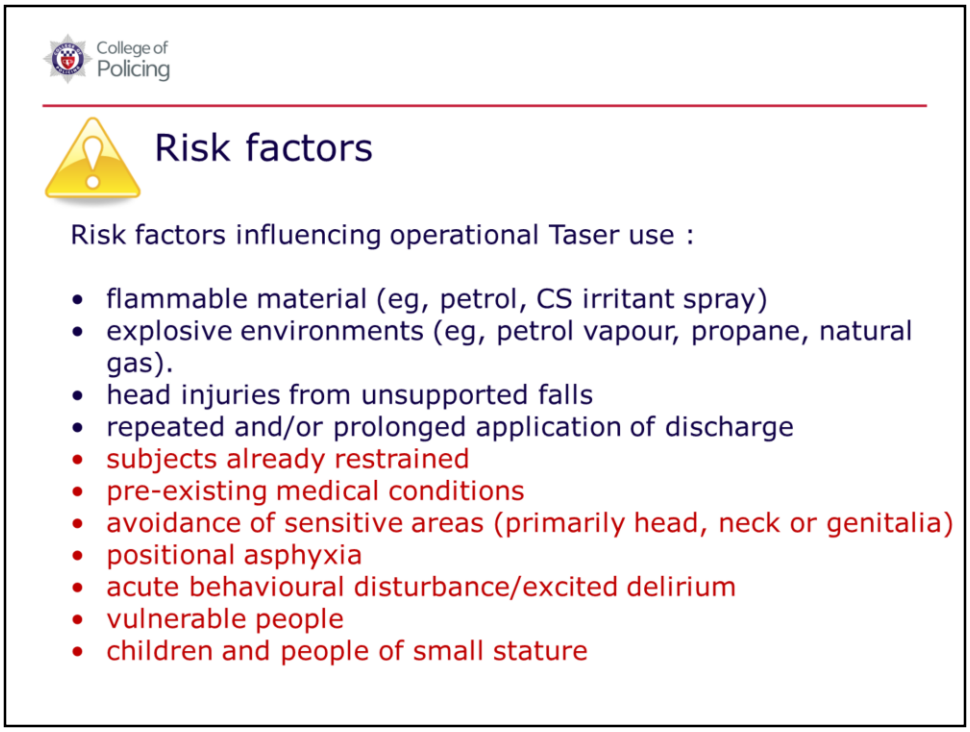
[redacted]

[redacted]

[redacted]



The situation needs to be monitored for development and effectiveness of response selecting correct controls and safe working practices. There are a number of risk factors which may influence the operational use of Taser. These can include but are not limited to:

(The risks identified in red are covered in other modules of the Taser training package or are pre-requisites to attend the course)

- flammable material (eg, petrol, CS irritant spray)
- explosive environments (eg, petrol vapour, propane, natural gas).
- head injuries from unsupported falls
- repeated and/or prolonged application of discharge
- subjects already restrained
- pre-existing medical conditions
- avoidance of sensitive areas (primarily head, neck or genitalia)
- positional asphyxia
- acute behavioural disturbance/excited delirium
- vulnerable people
- children and people of small stature

These risk factors are identified from operational experience, medical evaluation and manufacturers guidance.

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Multiple Taser deployment

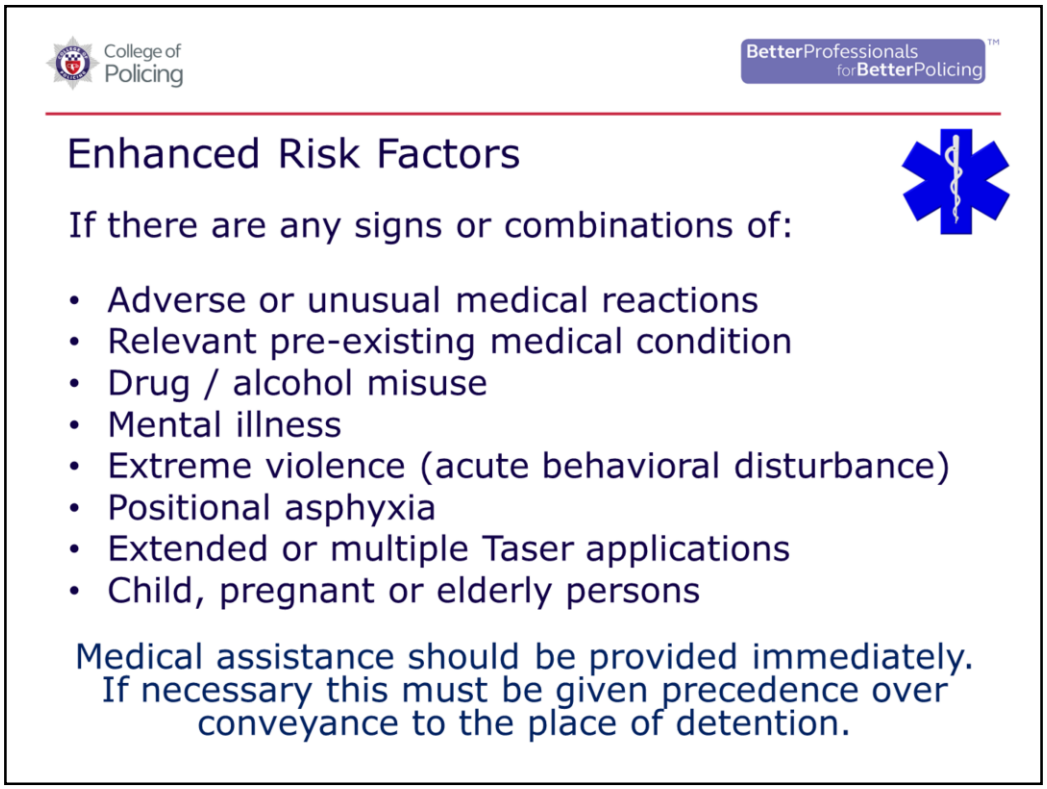
- Does not increase the voltage experienced
- Larger area of the body is likely to be incapacitated
- Consider the amount and effectiveness of multiple Taser discharges

[redacted]

Two Tasers or cross-connect (X2) can deliver 38 pulses per second, may increase injury risk

As with any increased use of force it is likely the risks will also increase and officers should be aware of such factors if deploying multiple Tasers. Where multiple Tasers are used this does not increase the voltage, just the areas of the body subjected to incapacitation and the amount of pulses of electricity per second that the subject endures.

[redacted]



Instructors should be conversant with- DOMILL version 6 report.

A great deal of work has been done internationally relating to subjects most 'at risk' of Taser. At present it appears that the more of the danger factors that are involved during a Taser deployment the more aware the operator should be aware of the likelihood of an adverse reaction.

However it must be borne in mind that in any stressful incident (involving Taser or not) it is likely that the same impact factors are likely to increase the risk of an adverse medical reaction following arrest following a violent confrontation.

Indicators of a severe medical condition

Someone with a severe medical condition may exhibit one or more than one of the following symptoms and behaviours.

apparently inexplicable and/or aggressive behaviour

apparently confused thinking

disorientation

hallucinations

acute feelings of paranoia

panic

shouting

violence towards others

unexpected physical strength

apparent ineffectiveness of irritant sprays

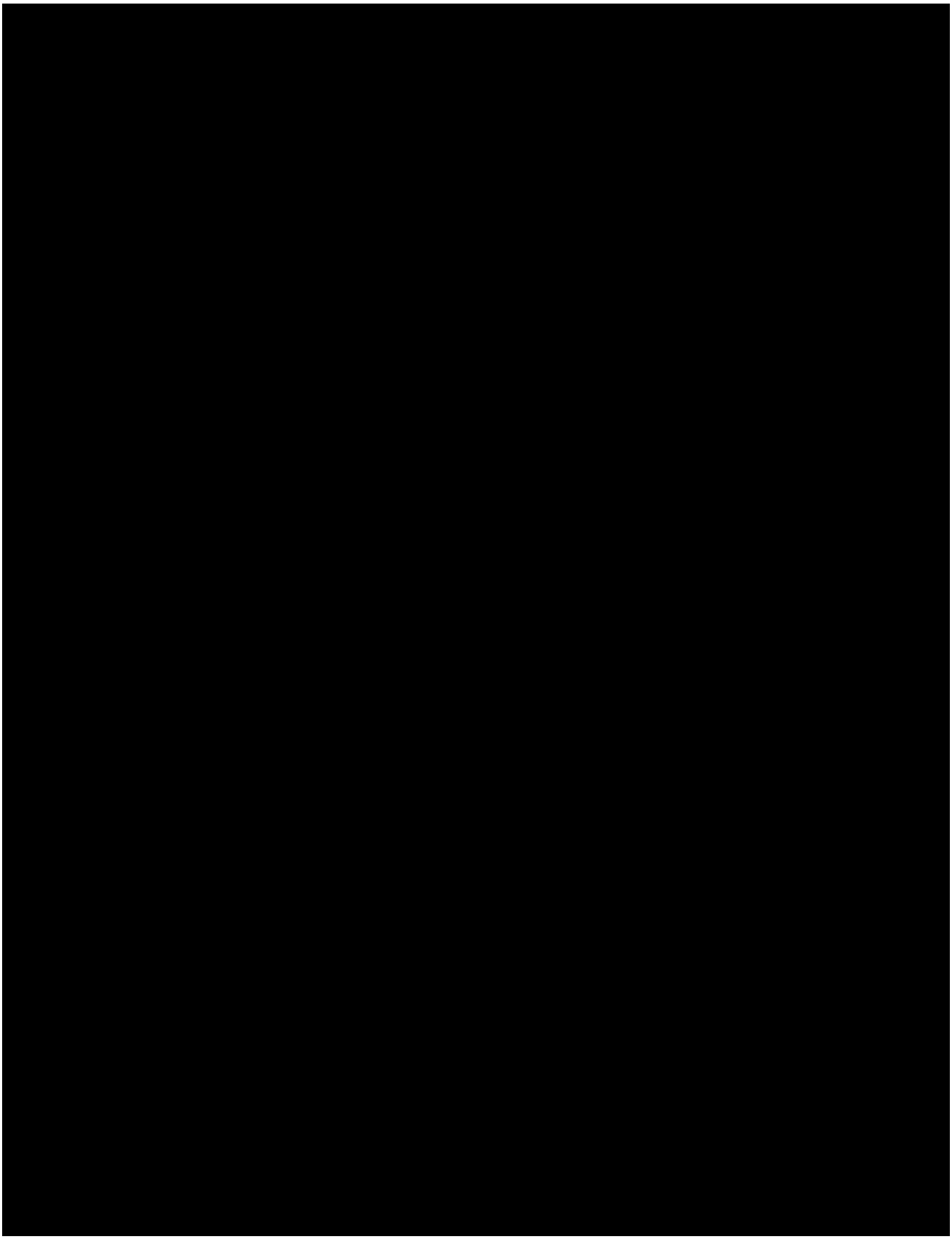
significantly diminished sense of pain

sweating, fever, heat intolerance

sudden tranquillity after frenzied activity.

Where a subject has been arrested and is exhibiting these characteristics, early medical advice must be sought and the subject must be kept under visual observation. This is particularly important in respect of restrained subjects who are under the influence of alcohol or drugs, or who are extremely obese or very small.

The method of restraint and transport should ensure that their windpipe does not become blocked and that they are not transported in a face down position as this can cause positional asphyxia



Officers should be cognisant of the increased medical risks associated with repeated or extended applications of Taser and the SACMILL recommendation that exposure duration should be minimised.

1. Pulling trigger deploys the selected cartridge (Normally the left cartridge). See figure 20 below.

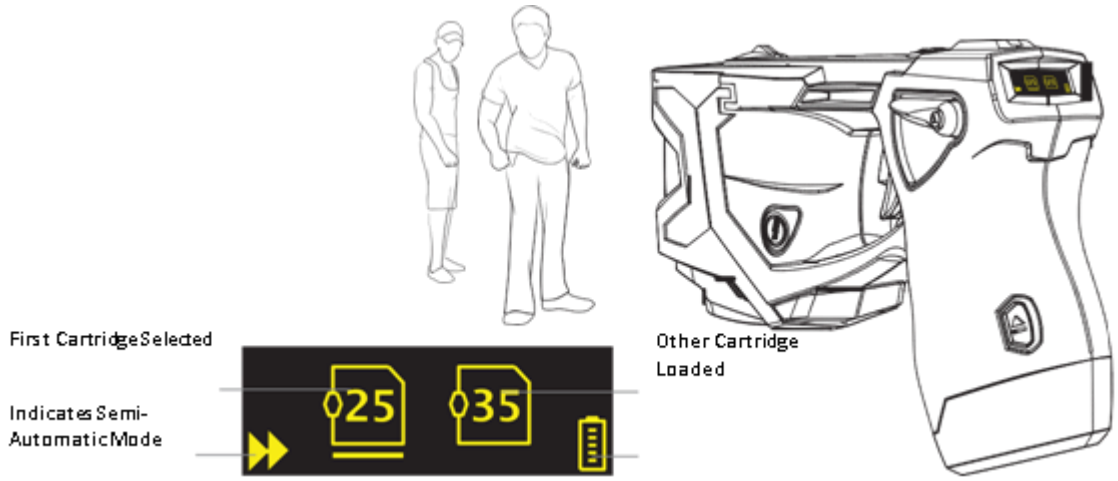


Figure 20

The X2 energises the first deployed cartridge. Releasing the trigger automatically selects the next cartridge while the first cartridge is deploying.

Pressing and holding the ARC switch will apply energy to both cartridge bays but will not deploy an unexpended cartridge. This allows additional cycles to be applied if justified and proportionate, without deploying the remaining cartridge. Officers should be cognisant of the increased risks associated with repeated applications of Taser.

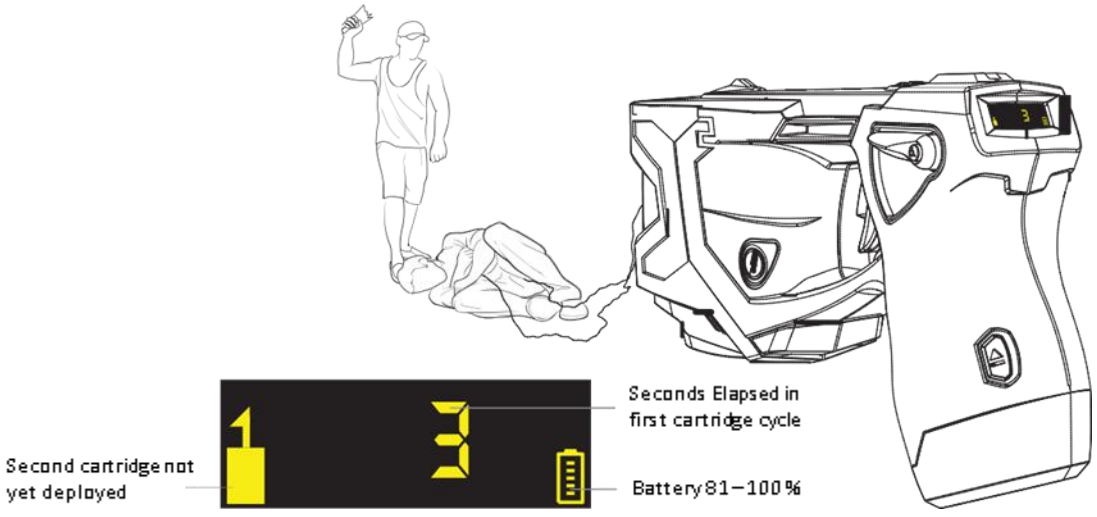


Figure 21

Officers should consider the position of their CED to achieve successful probe placement. It may be necessary to cant the CED, in a similar manner to a prone subject, for many quadrupeds.

Content 6

Dynamic risk assessments

Officers carrying out dynamic risk assessments need to be aware of their surroundings, changing activities, persons involved, expect the unexpected and be alert at all times.

They need to have all round awareness, effective communication skills, control, use trained responses and NDM based decision making.

Dynamic risk assessments can be applied to assess spontaneous incidents, assess situations upon arrival, assessing new information as the situation develops.

The situation needs to be monitored for development and effectiveness of response selecting correct controls and safe working practices.

Risk factors

There are a number of factors which may influence the operational use of CEDs. These include, but are not limited to:

- head injuries from unsupported falls
- repeated and/or prolonged application of discharge
- avoidance of sensitive areas (primarily head, neck or genitalia)
- pre-existing medical conditions
- positional asphyxia
- subjects already restrained
- acute behavioural disturbance/excited delirium
- vulnerable people
- children and people of small stature
- flammability (e.g. petrol, CS irritant sprays)
- explosive environments (e.g. petrol vapour, propane, natural gas)

These risk factors are identified from operational experience, medical evaluation and manufacturer's guidance.

Scenario based training in the use of CEDs is conducted in a way that emphasises the precautions and considerations relevant to risk factors above.

Further information:

- Detainees requiring urgent medical attention
- Use of Taser conducted energy device in custody
- Monitoring after Taser discharge
- DOMILL, Statement on the Medical Implications of Use of the Taser X26 and M26 Less-Lethal Systems on Children and Vulnerable Adults
- SACMILL, Statement on the Medical Implications of Use of the Taser X2 Conducted Energy Device System

(APP Armed Policing> Conducted energy devices (Taser)> 6.3 Risk Factors)

SACMILL has highlighted a risk of heart rhythm disturbance from CED discharge applied to the frontal chest over the heart. This risk may be higher in young or thin people because the heart is nearer to the chest wall (and nearer to the CED probe). If this disturbance occurs, the blood-pumping action of the heart may be reduced during the application of discharge and the person may faint. The shorter the duration of the discharge, the less likely that fainting will occur. Should a heart rhythm disturbance occur, it is more likely to have a detrimental effect in people who have an existing heart condition or who are intoxicated with certain drugs (including alcohol).

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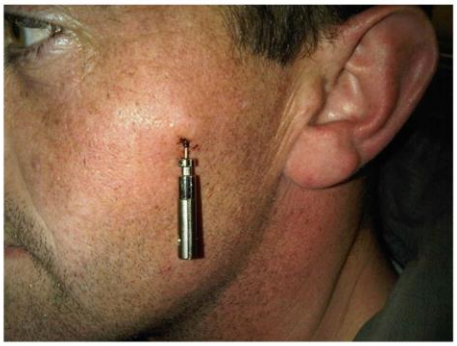
Medical Referral

- Where a subject is hit in the face, eyes or genitals
- Other area that causes you concern
- Or is discovered to have a pre-existing cardiac condition
- Or implanted electrical medical device that might lead to increased medical risk
- They must be immediately referred to hospital.

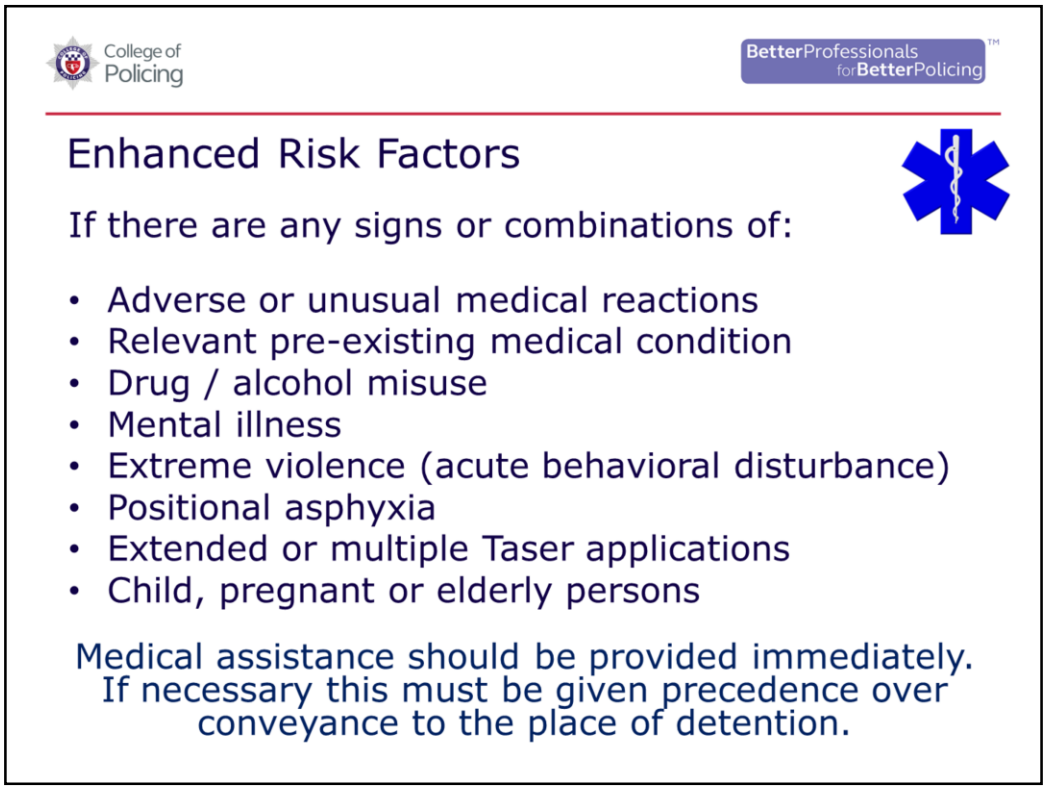


A secondary survey should be conducted for possible head injury

There is a school of thought that if a subject is hit in the eye with a probe that the Taser should remain on until the subjects arms have been restrained in order to prevent them pulling the probe out themselves thereby causing more damage. This remains a dynamic decision to be made using the national decision model, and while considering the legality of any such use of force in the circumstances. Where reference is made to implanted medical devices these include generic pacemakers, or vagus nerve stimulators.

Several people have been hit in the eye with a probe and not all have lost their sight, regardless of having received a full 5 second deployment.

DOMILL recommendations advise a check for head injuries due to the device locking the body solid and unable to break any fall.



Instructors should be conversant with- DOMILL version 6 report.

A great deal of work has been done internationally relating to subjects most 'at risk' of Taser. At present it appears that the more of the danger factors that are involved during a Taser deployment the more aware the operator should be aware of the likelihood of an adverse reaction.

However it must be borne in mind that in any stressful incident (involving Taser or not) it is likely that the same impact factors are likely to increase the risk of an adverse medical reaction following arrest following a violent confrontation.

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Medical Assessment

All arrested persons who have been subjected to the discharge of a Taser must be examined by a forensic medical examiner (FME) as soon as practicable after arrival at the custody suite

All arrested persons who have been subjected to the discharge of a Taser must be examined by a forensic medical examiner (FME) as soon as practicable after arrival at the custody suite.

SACMILL have endorsed DOMILL's existing medical statement and recommend FME examination to those who have been subject to Taser discharge. It recognises that some nurses and other healthcare professionals who are not registered medical practitioners may have the competence to examine and identify the full range of potential injuries and complications, their view is many will not.

Many forces now employ nurses to carry out work in the custody suites. The removal of Taser probes by nurses is in order and accords with national guidance. They will be appropriately qualified to examine and deal with this type of injury.

The rationale for the police doctor/FME examining those who have been subject of a Taser discharge is not purely relating to the probe injuries. Rather it is to ensure that they have not suffered any secondary injury e.g. did they fall and hit their head or suffer potential compression of the spine which the nurses would not be qualified to diagnose

Further information

National Circular 33/2011 – Custody Procedures post Taser Discharge

National Circular 01LL’2015 - Position Statement on the Post-Incident Clinical Review of People Subjected to Taser Discharge

Infection control

SACMILL considers that the risk of infection from tissue-penetrating probes should be borne in mind. Where probes have penetrated the skin, measures to reduce the chances of infection should be considered, such as swabbing the wound with an anti-sceptic wipe and applying an appropriate dressing, such as a plaster. This is particularly important in immunocompromised individuals, i.e. those with compromised immune systems. This would include those with uncontrolled diabetes. Where doubt exists, medical advice should be sought.

Probe related tissue injuries

SACMILL notes the increased risk of probe penetration with the X2 device, compared to its predecessors in the UK, due to its increased probe length and differing design. This may result in increased vulnerability of the great vessels in the neck, under-arm, groin and tissues in the chest/abdomen and a greater risk of uncontrolled bleeding, especially those people who are on anticoagulant medication or who have a disorder that impairs coagulation (blood clotting). People with coagulation issues may be at increased risk of internal bleeding as a result of probe penetration and/or head injury. Where coagulation issues have been identified medical advice should be sought.

It should also be noted persons of a small stature, including children, may be vulnerable to such tissue injuries given the thinner layers of tissue.

Content 3

Referral to hospital and monitoring

Effects

The usual reaction of a person exposed to CED discharge in probe mode is loss of some voluntary muscle control accompanied by involuntary muscle contractions. During the discharge the subject may:

- not be able to control their posture – consider risk of injury from uncontrolled fall
- experience their legs going rigid, which could be mistaken for kicking out (especially if they are in prone position)
- convulse, curl up in a ball, spasm, or stiffen (plank)
- experience intense pain
- call out or make involuntary vocal noises

- not be able to respond to verbal commands during the discharge
- be confused or disorientated after the cycle
- feel exhausted after cycle
- 'freeze' on the spot.

Loss of posture and resulting falls could result in head injury, either from the subject's head hitting the ground or from collision with nearby rigid objects (e.g. tables, chairs or walls). This may result in the subject falling to the ground, causing various secondary injuries, or being exposed to other risks.

(APP Armed Policing> Conducted energy devices (Taser)> 2.4 effects)

Officers should remain alert to this, check for, and be prepared to administer emergency first aid should a secondary injury be discovered or suspected (e.g. a subject who has suffered a head injury or becomes unresponsive).

In these circumstances consideration should be given to providing medical assistance immediately and referral to hospital. If necessary this must be given precedence over conveying the subject to a police station

Immediate referral to hospital

If an officer believes that a person on whom CED discharge has been applied has a cardiac pacemaker, vagus nerve stimulator or other electronic implanted device, immediate referral should be made to hospital.

Similarly, if the subject is found to have any other pre-existing medical condition that could be considered to increase their risk of a serious adverse medical event, immediate referral to a hospital should be considered.

(APP Armed Policing> Conducted energy devices (Taser)> 7.1 Aftercare)

Indicators of a severe medical condition

Someone with a severe medical condition may exhibit one or more than one of the following symptoms and behaviours.

- apparently inexplicable and/or aggressive behaviour
- apparently confused thinking
- disorientation
- hallucinations
- acute feelings of paranoia

- panic
- shouting
- violence towards others
- unexpected physical strength
- apparent ineffectiveness of irritant sprays
- significantly diminished sense of pain
- sweating, fever, heat intolerance
- sudden tranquillity after frenzied activity.

Where a subject has been arrested and is exhibiting these characteristics, early medical advice must be sought and the subject must be kept under visual observation. This is particularly important in respect of restrained subjects who are under the influence of alcohol or drugs, or who are extremely obese or very small.

The method of restraint and transport should ensure that their windpipe does not become blocked and that they are not transported in a face down position as this can cause positional asphyxia.

See J3.1, Dealing with vulnerable people

(See APP Detention and Custody > Acute Behavioural Disturbance)

(See APP Detention and Custody - Positional Asphyxia)

(See Personal Safety Manual> Module 4 Medical Implications, Page 7, Positional Asphyxia)

(APP Armed Policing> Armed Deployments> 4.3.2 Indicators of a Severe Medical Condition)

Medical assessment

All arrested persons who have been subjected to CED discharge must be examined by a forensic medical examiner (FME) as soon as practicable after arrival at the custody suite.

(APP Armed Policing> Conducted energy devices (Taser)> 7.1 Aftercare)

SACMILL (Scientific Advisory Council on the Medical Implications of Less Lethal Weapons) have endorsed DOMILL's (Defence Scientific Advisory Council Sub-Committee on the Medical Implications of Less-Lethal Weapons) existing medical statement and recommend FME examination to those who have been subject to CED discharge. It recognises that

some nurses and other healthcare professionals who are not registered medical practitioners may have the competence to examine and identify the full range of potential injuries and complications, their view is many will not.

Many forces now employ nurses to carry out work in the custody suites. The removal of CED probes by nurses is in order and accords with national guidance. They will be appropriately qualified to examine and deal with this type of injury.

The rationale for the police doctor/FME examining those who have been subject of a CED discharge is not purely relating to the probe injuries. Rather it is to ensure that they have not suffered any secondary injury e.g. did they fall and hit their head or suffer potential compression of the spine which the nurses would not be qualified to diagnose

Further information

ACPO Circular 33/2011 – Custody Procedures post Taser Discharge

ACPO Circular 01LL'2015 - Position Statement on the Post-Incident Clinical Review of People Subjected to Taser Discharge

(APP Armed Policing> Conducted Energy Devices (Taser)> 7.1 Aftercare)

DOMILL, Statement on the Medical Implications of Use of the Taser X26 and M26 Less-Lethal Systems on Children and Vulnerable Adults

CED information leaflets

At the earliest opportunity following arrival at the custody suite, a detainee who has been subjected to a CED discharge should be given an appropriate information leaflet describing the CED, its mode of operation and effects. This leaflet should be fully explained.
The following leaflets are available:

- Advice to people subjected to TASER® discharge
- Medical Management of People Subjected to Discharge from Conducted Energy Devices ('tasers') Advice to Health Care Professionals
- In-Custody Management of Detainees Subjected to TASER® discharge *Advice to Custody Officers and other non-medical staff*

The Faculty of Forensic and Legal Medicine (2013) Taser: Clinical Effects and Management of Those Subjected to Taser Discharge guidance provides additional advice to those subjected to

discharge as well as information for GPs and hospital clinicians to use as appropriate.

Further information

DOMILL, Statement on the Medical Implications of Use of the Taser X26 and M26 Less-Lethal Systems on Children and Vulnerable Adults

SACMILL, Statement on the Medical Implications of Use of the Taser X2 Conducted Energy Device System

(APP Armed Policing> Conducted Energy Devices (Taser)> 7.2 CED Information leaflets)

In order to ensure the above procedures are implemented, where the officer that has discharged the CED doesn't accompany the subject to either hospital or custody facility, there should be measures in place to ensure that the circumstances of the CED use are accurately communicated to those responsible for ongoing care such as the custody officer or medical professionals.

Content 4

Post-use Procedures

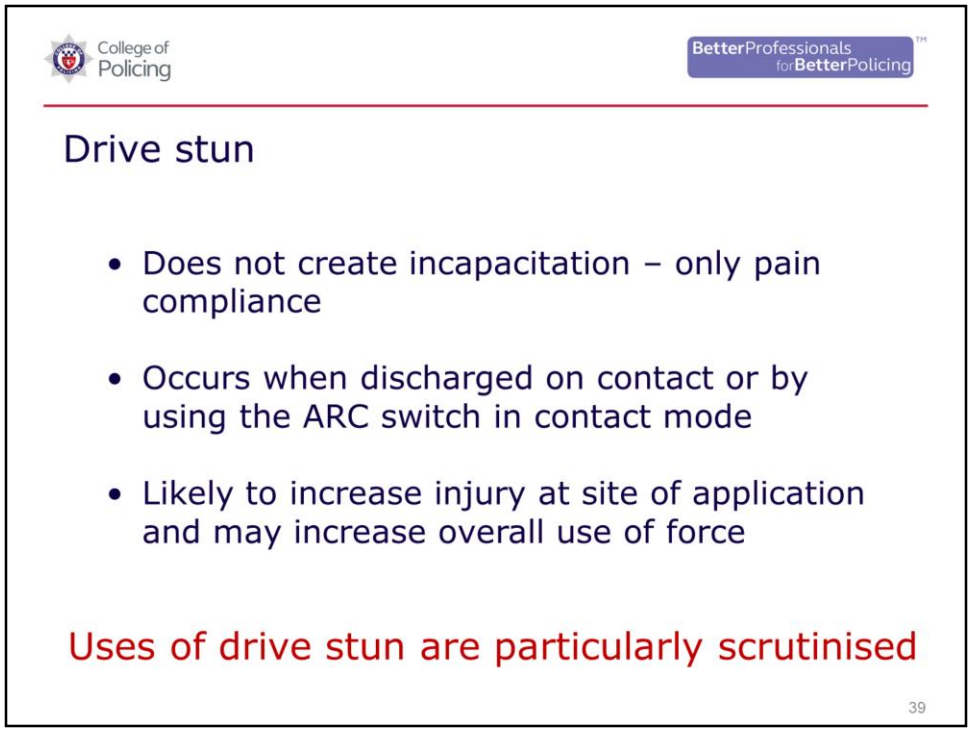
In any situation where a CED is discharged, appropriate post-use procedures should be implemented depending on the nature of the injury or harm caused. Every use will warrant, where possible, consideration of minimum standard forensic retrieval.

Post incident procedures are scalable and reference should be made to local force standard operating procedures (SOPs) as to how this is to be implemented.

Evidential collection of equipment

Forces should consider the availability of evidence collection equipment, including cameras/body worn video and appropriate packaging.

Once the probes have been removed, they must be secured as evidence and any injury or damage noted. Probes removed from the body should be considered as biohazards. Suitable evidential containers need to be readily available for the removed probes, which must then be examined to ensure they are complete. Incomplete probes may indicate that part of the probe has remained in the subject. Medical professionals should be advised if this is the case.



Use of drive stun is a recognised, use of Taser however comes with caution as there are significant concerns about the use of these devices in this manner. However it is not included in the practical training. There are superior techniques such as close probe deployment and follow-up three point contact.

The application of drive stun involves using the device in a way which does not cause incapacitation, but merely causes a pain effect. As the effects of drive stun do not create incapacitation it may therefore not be effective at bringing a violent encounter under control and may also lead to an overall increase in the use of force.

Drive stun tends to occur in either of the following circumstances:

- Taser is discharged on contact with the subjects body (but has not then been followed up with three point contact mode);
- The device is placed against the subjects body and the ARC switch depressed (probes not fired)

Due to the close proximity of the device to the skin and potential for prolonged exposure, it should be recognised that there may be an increased injury risk to the subject at the point of application.

In the past drive stun has been associated with a high incidence of complaints. It should be noted that cases that should be considered for voluntary referral to the IOPC include those where a CED is used in drive stun mode (see Module 5.1 for details)

College of Policing

CED Curriculum and Training

Introduction

Overview

This instructor's guide is provided to explain how the CED training packages and curriculum should be delivered. It provides guidance on:

- The CED curriculum
- Instructor competence
- Minimum contact hours
- Course construction and suggested course timetable
- Assessment
    - Qualification shoot
    - Scenario based assessment
    - Written knowledge check

Throughout this document the term 'Taser' is used and applies to both the Taser X26 and X2 models. Where a specific model is referenced then it is referred to by its specific model number i.e. X26 or X2.

Assessing applicants for initial Taser training

These are 'gateway' standards that must be met before an applicant can be considered for initial training as a Taser user. This is not an exhaustive list, but applicants should be eligible, suitable and supported. Forces / agencies may include other criteria they consider necessary.

Eligible

- Applicant holds the office of Constable, or equivalent agency rank or grade, and meets the eligibility criteria as set out in the role profile. (See module J1 for current role profiles).

Suitable

- Applicant possesses sound judgement.
- Applicant can demonstrate a knowledge and understanding of the national decision model (NDM) to resolve incidents involving conflict.

- Applicant has demonstrated maturity of action in the workplace.
- Applicant has demonstrated an ability to use legitimate force in a proportionate manner.
- Applicant has an acceptable professional standards / complaints and misconduct record.

Supported

- Application has been supported and has been 'signed-off' by an officer of at least the rank of Superintendent.

National Police Firearms Training Curriculum

1. CED Curriculum

CED training is supported by a modular curriculum, as part of the National Police Firearms Training Curriculum (NPFTC), irrespective of whether the officer is firearms trained. This is due to the Code of Practice on the Police Use of Firearms and Less-lethal Weapons being engaged and providing a supporting infrastructure of quality assurance through the College of Policing firearms training licensing process.

Module J1, Guidance and Roles, contains a number of nationally agreed role profiles that support and deliver the operational use of Taser. Those role profiles consists of units and modules of training, documented within the NPFTC, which include training content, learning outcomes and assessment criteria to be achieved.

These roles should only be performed by officers/staff that have been selected, trained and assessed in line with this guide and the curriculum.

Course construction

1. Introduction

The initial CED training course consists of the following key elements:

- Classroom based learning (based on PowerPoint presentations)
- Practical exercises and drills
- Live fire training
- Scenario based training
- Assessment

Refresher training will be supported by the dedicated refresher PowerPoint presentation provided to forces by the College of Policing. All the other above elements should be included, however training design can recognise prior learning, experience and competence.

[redacted]

[redacted]

To ensure standardisation of delivery, the content of the PowerPoint presentations **should be used in full**. The presentations may be enhanced with additional content, such as local SOPs and operational examples.

Where local good practice has been identified, or where enhancements to (or issues with) CED training have been identified, these should be communicated to the College of Policing so that good practice identified at a local level may be assessed and, where appropriate, cascaded nationally.

[redacted]

2. Written knowledge check

A written knowledge check is provided for both initial and refresher training. It focusses on key areas of the curriculum, particularly those that are knowledge based.

Candidates' scores can be recorded, as part of their training record, but the College of Policing do not require the retention of the actual answer paper. This is because the knowledge check is a means of checking knowledge and understanding at the conclusion of a period of learning, and it is expected that incorrect answers are subject to discussion and/or clarification to ensure the candidate understands the subject matter.

Therefore retention of merely the answer sheet does not reflect the full process of learning and eventual outcome.

Where a candidate fails to achieve the required standard, then a development plan should be considered to address gaps in knowledge and understanding. This development plan should be cognisant of any identified common themes in a candidates incorrect answers.

Where a candidate falls significantly below the required standard then they should repeat the period of learning.

3. Qualification shoot

The qualification shoot is divided into a series of "details" that examine different assessment criteria. Each detail requires the officer to competently perform the required skill areas.

Where an officer fails to achieve the required standard in no more than one detail they are allowed to repeat that one detail and may be given a short period of development and feedback. (Same day)

Where an officer fails to achieve the required standard in more than one detail then they should be subject to remedial training prior to attempting the shoot again.

[redacted]

Management of Taser training

1. Tiered training delivery

In order to deliver national standardisation, CED training follows a 'tiered' training system.

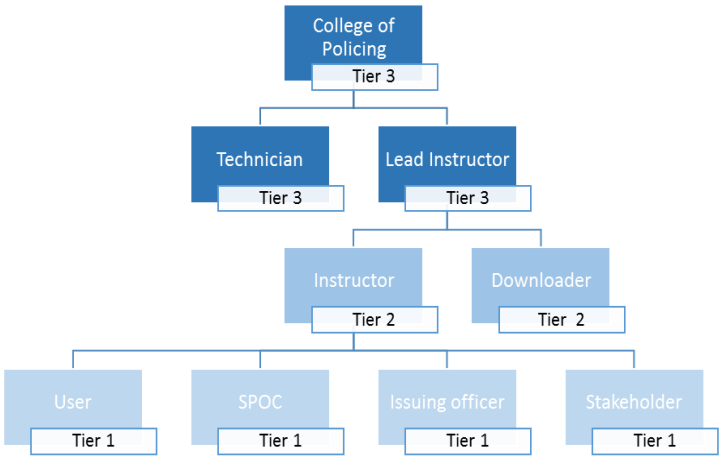
The College of Policing, with the support of the national practitioner group made up of experienced instructors, deliver both the lead instructors' course and the technicians' course. This is referred to as tier 3 training (or 'train the trainers') and is delivered at a national level.

Lead instructors, on return to their force, are authorised to deliver local instructors courses (tier 2), these instructors can then deliver user, SPOC, issuing officer and stakeholder training.

Where a lead instructor is also a competent technician they can also deliver downloader training.

This system therefore means that training should be no more than twice removed, and in some cases only once removed, from the original delivery by the College of Policing and UK practitioner group, despite being cascaded to many thousands of officers.

This approach, in conjunction with a national curriculum and standardised training products, delivers the highest level of standardisation realistically achievable.



2. Role of the CFI

Under the College of Policing training licence process the CFI has identified responsibilities in relation to CED training irrespective of whether it is for STOs or armed officers. Those responsibilities include:

- Approve the delivery of **all** CED training, including CED training by specially trained officers (STOs).
- Ensure Taser training is delivered in accordance with the requirements of the curriculum, including this guide.
- Oversee the management of risk and the safe delivery of all Taser training.
- Ensure an effective and accurate audit of all Taser training is maintained, in order to evidence compliance against the officers' role profile.

- Ensure portfolios are maintained for Taser instructors and lead instructors which clearly identifies the modules and units of the NPFTC which they are occupational competent to deliver.

Typically this would include:

- Taser lead instructor
    - Modules J1-J5 and J8 (units J8.1 to J8.5)
    - Where competent as a technician, J6 and J7
- Taser instructor
    - Modules J1-J5 and J8 (units J8.1 to J8.4)

3. Taser lead instructors and Taser instructors

Taser lead instructors and Taser instructors are trained in accordance with the requirements of the role profiles in module J1. In addition:

- All newly qualified Taser instructors should complete a mentoring and accreditation process approved by their CFI prior to the delivery of any Taser training without the support of a mentor. This process will be detailed in the Taser training SOPs, and will be managed in their individual instructor portfolio.

- Taser instructors must deliver a minimum of **24 hours** contact time of Taser related training (i.e. based on modules J1 to J5) each training year. Taser instructors who are also national firearms instructors (NFIs) already undergoing a peer assessment process as detailed in the NPFTC Introduction, need not demonstrate 24 hours of dedicated Taser training contact time provided that they can demonstrate Taser training content within their existing 60 hours.

- During a training year – 1st April to 31st March, all full-time and part-time Taser instructors, including those that are NFIs,need to be assessed annually on at least two separate occasions covering the four areas;

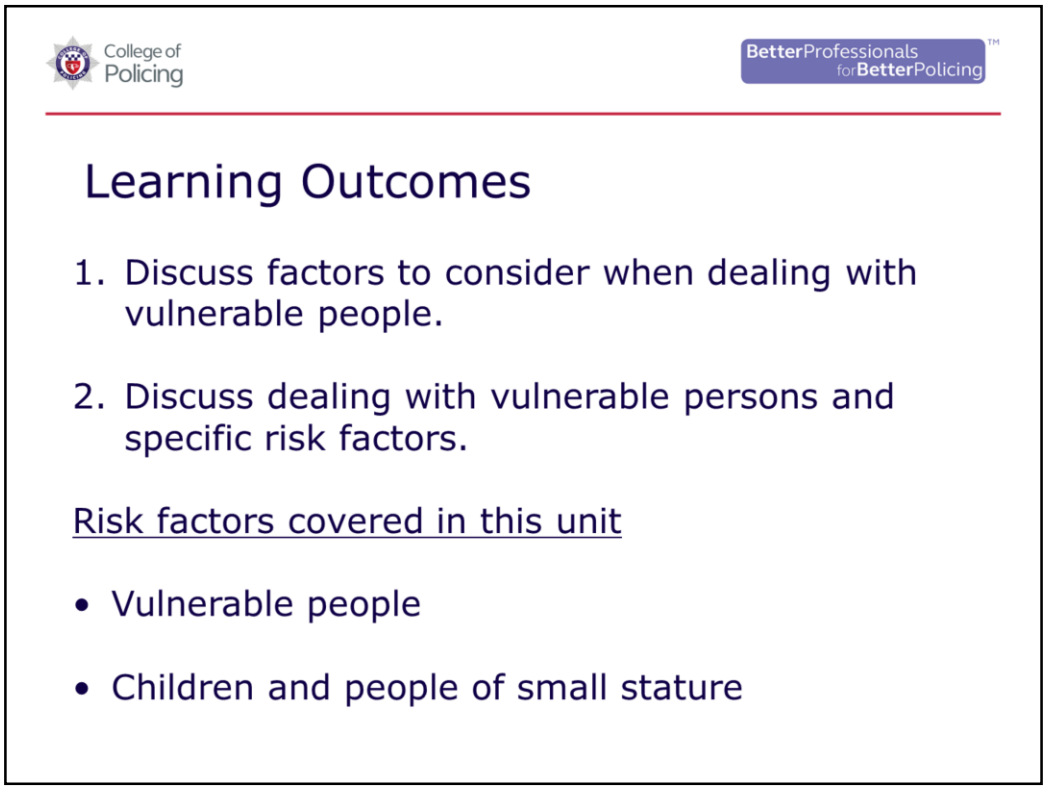
    - Teaches Taser associated subjects
    - Conducts Taser ranges

- Conducts Taser drills and exercises
- Conducts Taser scenarios

The range and exercise session assessments should not be combined

- Each police force, agency or organisation will maintain sufficient numbers of Taser Lead Instructors and Taser instructors to facilitate Taser training in line with the role profiles contained in Module J1.
- Each force, agency or organisation will also identify a suitable number of nominated lead instructors whose details will be made available to the College of Policing and held on a professional register.
- The main purpose of Taser lead instructors is the in force training of Taser instructors and the standardisation of training to national standards. There is no requirement for Taser lead instructors to be present for all Taser user training.

[redacted]



Lists the

Lists the areas to be covered by the presentation, as the other risk factors have been dealt with in units J2, and J5

The police response to all incidents supports the service's commitment to valuing diversity and treating everyone with dignity and respect. People may become vulnerable due to environmental and behavioural influences, or emotional or mental distress. This may include persons who are behaving in a manner which suggests they are attempting suicide possibly by provoking the police to shoot them, or to use force against them.

Similar issues may also be relevant when dealing with persons with:

- Medical conditions, such as epilepsy

- Physical disability, such as hearing impairment
- Communication difficulties, such as having a different first language
- Mental illness
- Children

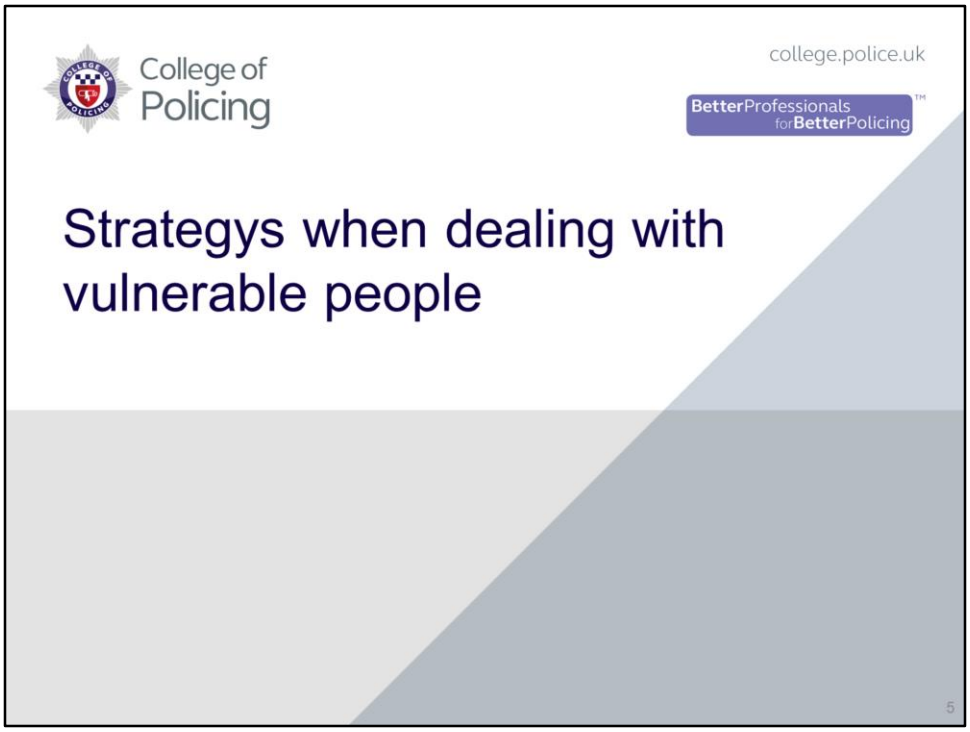
This presentation seeks to aid recognition of some of these issues so that, where possible, that vulnerability can be reduced and provide an appropriate response.

Whilst it is recognised that students may have had training in dealing with vulnerable people, either as authorised firearms officers from the National Police Firearms Training Curriculum, or from the National Personal Safety Programme, it should be recognised there are particular issues concerning a person's vulnerability and Taser consideration and use. Therefore the delivery of this content in context with Taser use is mandated.

areas to be covered by the presentation

There is no specific definition for the term ‘vulnerable’ people.

Is can be safe to assume that people that come in to contact with police may be vulnerable in some way and this may influence the police’s response when dealing with that individual. It should be made clear that being disabled does not automatically make you vulnerable and it should be the total of the information available that can be gathered which should be considered.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Strategys when dealing with vulnerable people
5

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Diffusing the situation

- ✓ Be prepared to back off
- ✓ Use of effective cover
- ✓ Give space and time if possible
- ✓ Early negotiation
- ✓ Evacuate immediate area

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This may allow:

- the effects of drink or drugs to wear off
- mental / emotional distress to decrease
- the tension to diffuse
- positive communication and contact to be established
- time to plan.

Defusing the Situation

The following actions can help create opportunities for the individual and officers to have more time and space to defuse the situation:

Be prepared to back off

Use of effective cover

Give space and time if possible

Early negotiation

Evacuate immediate area

This may enable:

- tension to be diffused
- officers to have more time to assess the person's vulnerability
- the effects of alcohol or drugs to wear off
- positive communication and contact to be established
- the level of mental or emotional distress to decrease.

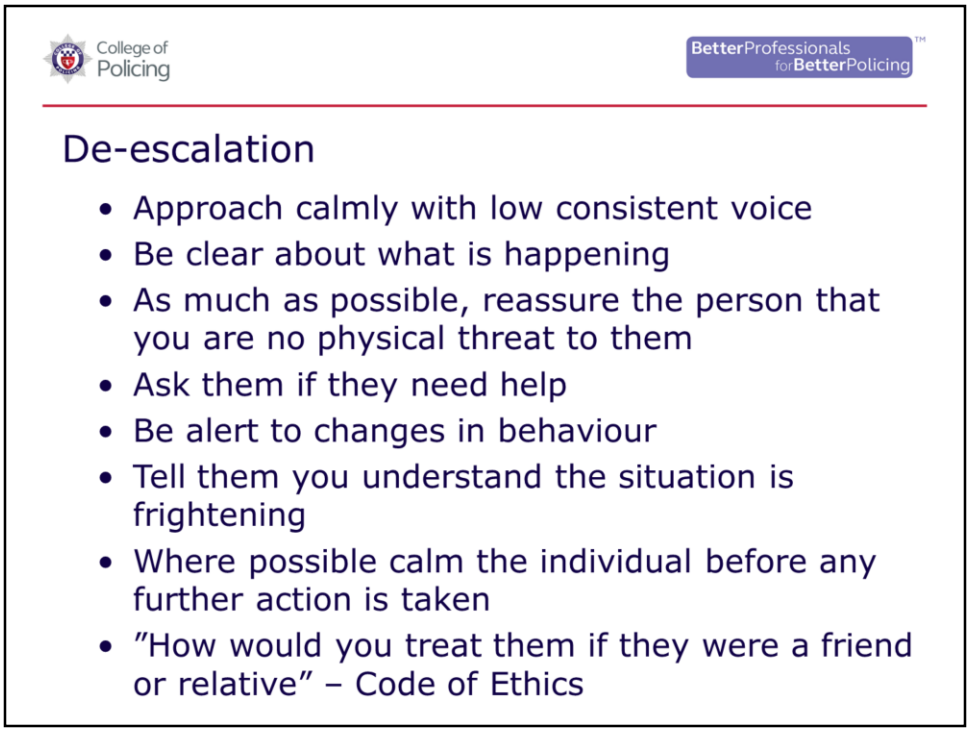
This may result in more positive and constructive communication with the subject, allowing the situation to be dealt with in a controlled manner.

(APP Armed Policing> Armed Deployments> 4.2.4 Defusing the Situation)

The more information we can get about the person the more we will be able to help. Our ARV and SFO colleagues all now receive mandatory training in this field. We can see that when we are dealing with people who are vulnerable, emotionally or mentally distress, suffering from mental ill health and when dealing with children and young persons the potential solutions largely are the same.

Problems exist with backing off but in certain circumstances it can achieve. Are we giving the person too much space. Are others endangered as a result?

The use of effective cover means also considering marshalling police resources with cover from view so as not to escalate the situation unnecessarily.



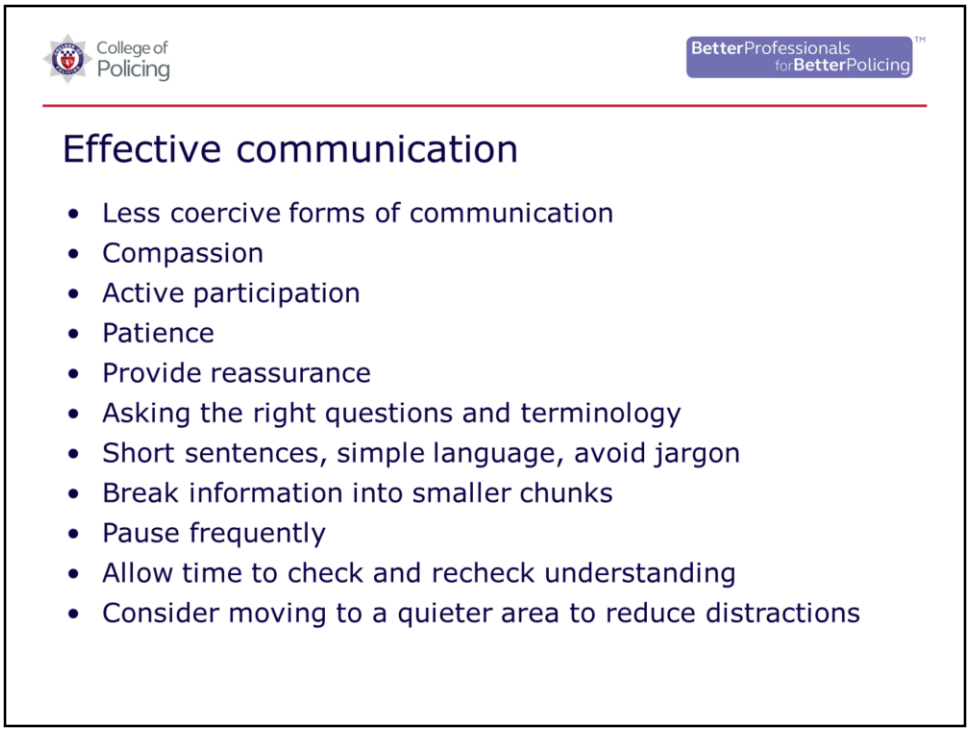
De-escalation is an approach and range of tactics that may be used by the police or other professionals to calm an agitated individual to reduce or prevent the use of force or restraint.

Verbal de-escalation and containing a disturbed or confused and vulnerable person in a calm, ideally familiar, and closed environment may be safer and less traumatic for the individual. It may reduce the need for physical restraint and sectioning.

Practitioner experience suggests that, where possible, officers and professionals should maximise the time and space provided so that an individual is offered every opportunity to calm down.

Failure to listen and actively engage in dialogue to draw out an explanation for apparently aggressive or odd behaviour represents a missed opportunity to de-escalate and resolve a situation informally before arrest and restraint may be necessary. An individual who is frightened, confused or injured may appear to be experiencing mental illness, but this should not be assumed before the subject has had a good opportunity to explain what is going on.

www.app.college.police.uk/app-content/mental-health/mental-vulnerability-and-illness/#de-escalation



Consider posing the questions, 'what is effective communication' and then 'what are barriers to communication' in order to illicit the detail from the students.

How can communication style be improved?

Research has indicated that police officers who participate in training programmes that emphasise verbal (eg, word choice, tone of voice) and non-verbal (eg, facial/body language, demeanour) de-escalation skills felt these were worth implementing in their daily work (Hanafi 2008). The officers believed that these skills would help them put individuals in mental health crises at ease and reduce the risk of injury to both parties (Silverstone et al 2013).

Qualitative and survey research has identified the following communication techniques as being potentially effective during interactions between police officers and people with mental health conditions:

Less coercive forms of communication – Livingston et al (2014a) found that people who perceived the police as being less coercive when communicating with them were typically more satisfied with their interactions and more likely to think they had been treated fairly and with respect.

Practitioner experience suggests that compliance is negatively affected and risk levels may increase when the communication style becomes negative or patronising.

Compassion – Research by Watson et al (2008) found that people with various mental health conditions were more likely to be satisfied with their police interactions when officers were compassionate and respectful, taking extra time to show concern, check their welfare and talk to them, putting them at ease. Additionally, people believed officers should demonstrate these skills more when interacting with them (Livingston et al 2014b).

Active participation – People were more likely to be satisfied when officers directly communicated with and involved them in the interaction, allowing them to 'have a voice' to explain their version of events (Watson et al 2008, Gregory and Thompson 2013).

Patience – People recommended that officers should interact with them in a patient and calm manner to show they are there to help (Watson et al 2008).

Asking the right questions and terminology - Unfortunately, mental ill health and disabilities often carry an associated stigma. This may present a barrier to effective communication and cause people to feel less able to provide information to the police or others about their health needs.

Officers and staff should be careful in choosing the terminology they use to describe mental ill health or learning disabilities to avoid causing offence and distress.

Ask questions such as: 'Do you have any difficulties that I may not be aware of?' if an officer 'has any suspicion, or is told in good faith, that a person of any age may be mentally disordered or mentally vulnerable' People with mental ill health or vulnerabilities should not be referred to using their illness as a label. For example, referring to someone as a 'schizophrenic' instead of a person first is negative and dehumanising.

Officers and staff should also understand that misinterpretation can cause anxiety and mistrust that increases risk.

Use short sentences using simple language and avoid jargon

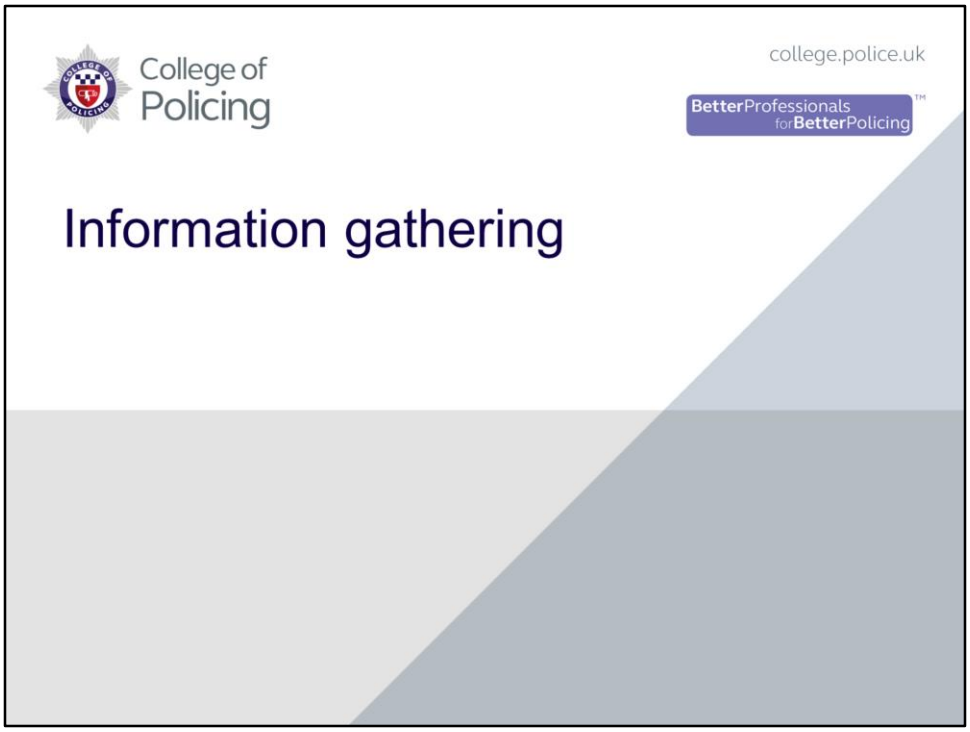
Break information into smaller chunks so that one idea or concept is explained at a time – for example, if arrested, explain one at a time who can be considered as an appropriate adult rather than read out the list

Pause frequently, so as not to overload the person with words

Allow time to make sure that the person has understood, and recheck the person understands you – for example, 'Can you tell me what I have just said so I know I have explained it properly?' (be aware that learning disabled people may have stronger receptive (understanding) communication skills than expressive skills, and a person's expressive speech may sometimes give an impression of better comprehension than is actually the case, so check their understanding)

If it is a busy environment with many distractions, consider moving to a quieter

location as some people may find it hard to concentrate in such a busy place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Information gathering

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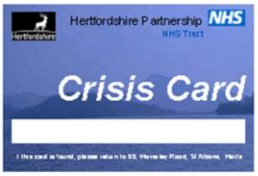
Sources of information

- The individual themselves
- The person who reported the incident
- Any medical professionals on scene (or associated with the individual)
- Next of kin, family, friends and known associates
- Local street triage/community or mental health nurse/crisis services
- Local mental health trust unit/GP/relevant local clinic
- NHS medical database
- Child and adult social services
- Appropriate adult services
- Liaison and diversion unit
- Police information systems
- CCTV



Sources of Information:

The individual themselves

People experiencing mental ill health or other vulnerable people who may not understand or correctly interpret police efforts to communicate are at increased risk of not having their immediate needs adequately met.

When the police are in contact with people who are mentally vulnerable, have mental ill health or learning disabilities, the most important source of information will be the individuals themselves, some of whom will carry information about their circumstances and needs. In many instances, the individual may be able to provide the name and details of those who should be contacted if they need assistance.

Crisis cards' or other information cards are sometimes carried by people who have communication difficulties or who may find it difficult to communicate when in a crisis. The cards provide a range of information, from personal details of the individual and those of a trusted person to be contacted in a crisis or emergency, to advice on how to respond to and communicate with the individual (for example, details of approaches a person finds helpful to alleviate distress).

The absence of such a card does not mean that the individual does not have a particular disability or support need.

Information from parents, carers, family and associates

Parents, carers, family or others who know the individual experiencing mental ill health or with learning disabilities can be an important source of information and support in a range of situations, for example:

where the police are trying to identify the person's needs

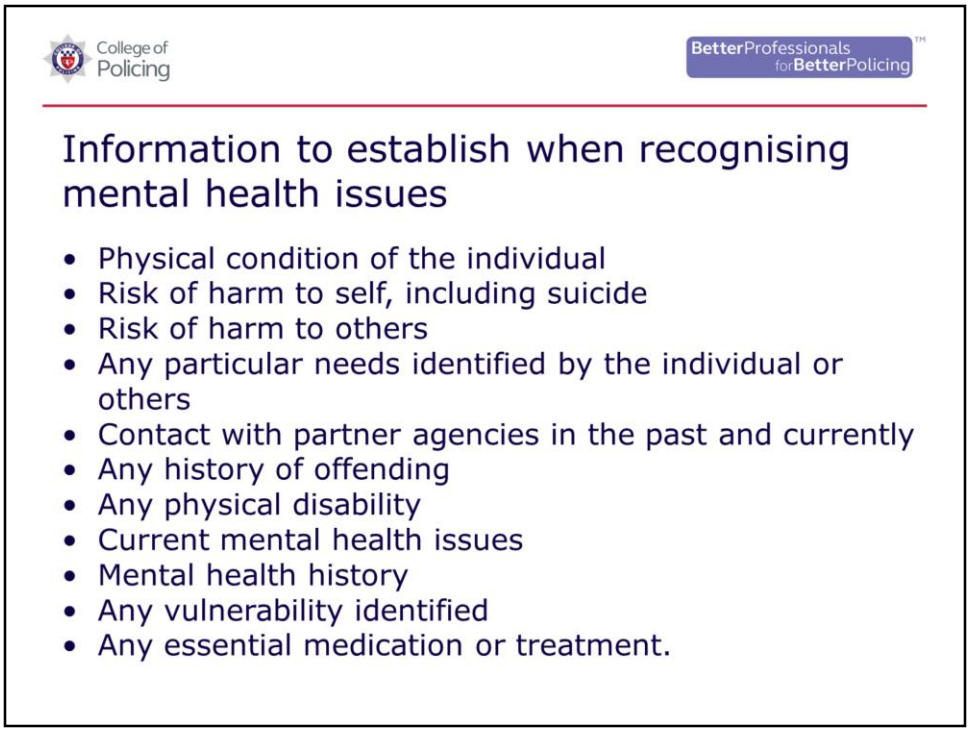
where an individual is in crisis or otherwise has difficulties communicating

when the police are planning action involving the individual, for example, assisting healthcare professionals by using police powers under section 136 of the Mental Health Act 1983 (MHA 1983).

Consulting people who know the individual well, and asking them about things such as the best way to approach the person, their habits, or the layout of their home, is likely to help the police deal with the situation in a way that causes as little added distress as possible. An attitude that is empathetic and considerate is likely to gain the person's trust and cooperation and achieve a better outcome.

Where possible, the police should seek the views and consent of the individual in question to interact with their parents, carers, family and associates. Police officers and contact management staff should be aware that the people providing information may also require support and advice about what is happening and why, and what they can expect from the whole process.

It is also important to be honest, factual and not to make promises when communicating so as not to set unrealistic expectations. For example, saying 'we will take you to hospital where you will get help' may lead to people feeling rejected when they are assessed at hospital and then discharged. A more factual explanation might be: 'we will take you to hospital to be seen by a mental health professional and you can talk to them about what support you need'.



The priorities of the Police Service in responding to people with mental health issues are to:

Respond to individuals on the basis of need in the context of a multi-agency response to people with mental health issues;

Ensure that people with mental health issues have access to justice whether they are victims or witnesses, suspects or offenders.

Ensure that staff at all levels have the knowledge required for their role to recognise and identify people with mental health issues and understand the responses required by this guidance;

Adopt a multi-agency response to people with mental health issues wherever possible;

Take appropriate action against offenders so that they can be held accountable through the criminal justice system.

The information to establish when recognising Mental ill health issues;

Physical condition of the individual *(e.g. any need for immediate care due to urgent medical needs such as severe malnourishment / injury);*

Risk of harm to self, including suicide *(e.g. any immediate need for care to prevent physical harm such as a traffic accident)*;

Risk of harm to others *(including named individuals if appropriate, e.g. family*

member/partner/child);

Any particular needs identified by the individual or others *(e.g. medical treatment);*

Contact with partner agencies in the past and currently;

Any history of offending *(e.g. violence or damage to property*).

Any physical disability;

Current mental health issues;

Mental health history;

Any vulnerability identified *(e.g. age);*

Any essential medication or treatment;

Crisis Cards

carried by people with mental health issues who may have communication difficulties or may find it difficult to communicate when in crisis.

These cards can provide the following information:

Personal details of the individual *(eg, home address);*

Contact details for a trusted person to be contacted in a crisis or emergency;

Details of the mental health condition and symptoms;

Details of any medication or treatment;

Explanation of any individual needs *(eg, religious requirements, preference to be dealt with by someone of a particular sex) and advice on how to respond to, and communicate with, the individual;*

Advance directives relating to treatment *(eg, particular treatment that the individual would not consent to).*

Practitioners should be aware that the above indicators are seldom definitive proof of mental ill health or learning disabilities. There may be other explanations for such behaviour:

Physical illness: a person's behaviour and mental health may be affected by a physical medical condition such as a head injury, infection or diabetes.

Medication: for example, someone slurring their words might indicate that they are using anti-psychotic medication that affects speech.

Other intoxication: the person may be intoxicated by alcohol, drugs or so called 'legal highs'.

False behaviours: Officers and staff should treat all indications that a person is experiencing mental ill health, is vulnerable or has a learning disability as genuine. While a person may seek to mislead the police or other services, when in doubt, officers should consider all available information and consult with mental health professionals. In this situation, officers should record their observations, responses and actions alongside any additional available information and must be guided by the NDM.

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Aspects of communication

- inappropriate responses to questioning
- apparent suggestibility
- poor understanding of simple questions
- confused response to questions
- speech difficulties
- difficulty reading or writing
- unclear concepts of times and places
- problems remembering personal details or events
- poor ability to cope with interruptions
- poor handwriting that is difficult for others to read
- difficulty with filling out forms
- inability to take down correct information or follow instructions correctly
- talking continuously, or slowly and ponderously
- repeating themselves.

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Environmental and behavioural influencers

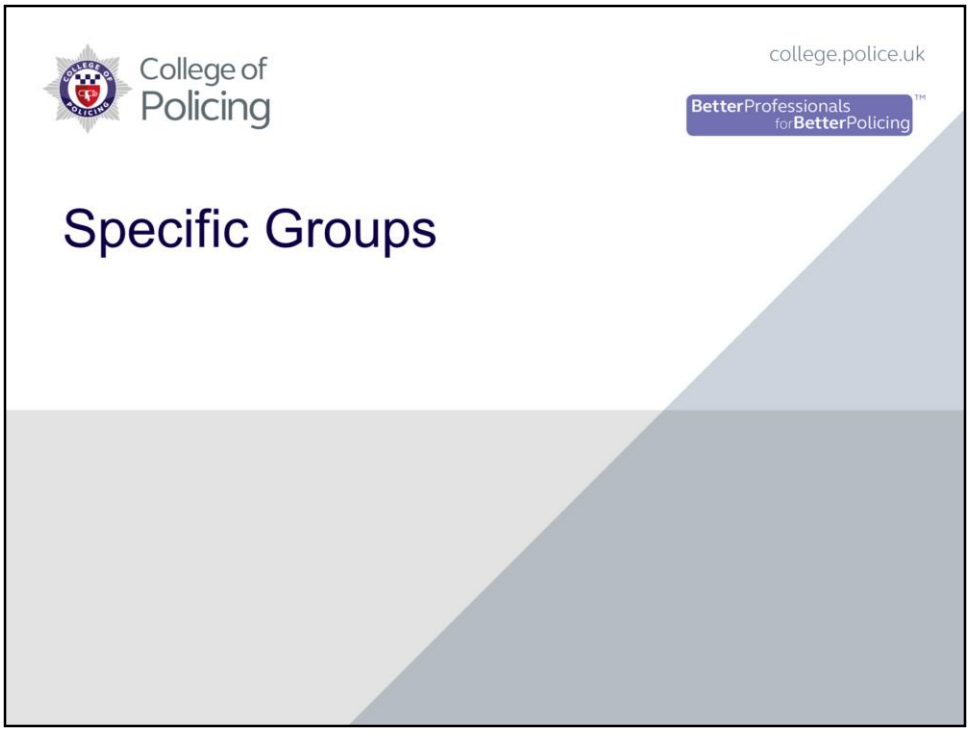
- crowd dynamics
- peer pressure
- environments where communication is difficult

- sensory impairment
- communication difficulties
- the effects of drugs or alcohol
- movement impaired or exaggerated by a medical condition
- learning difficulties
- physical or mental impairment.

Environmental and behavioural influencers can affect a subject's behaviour and their response to any contact with police officers. These influencers (sometimes referred to as moderators) can include issues such as:

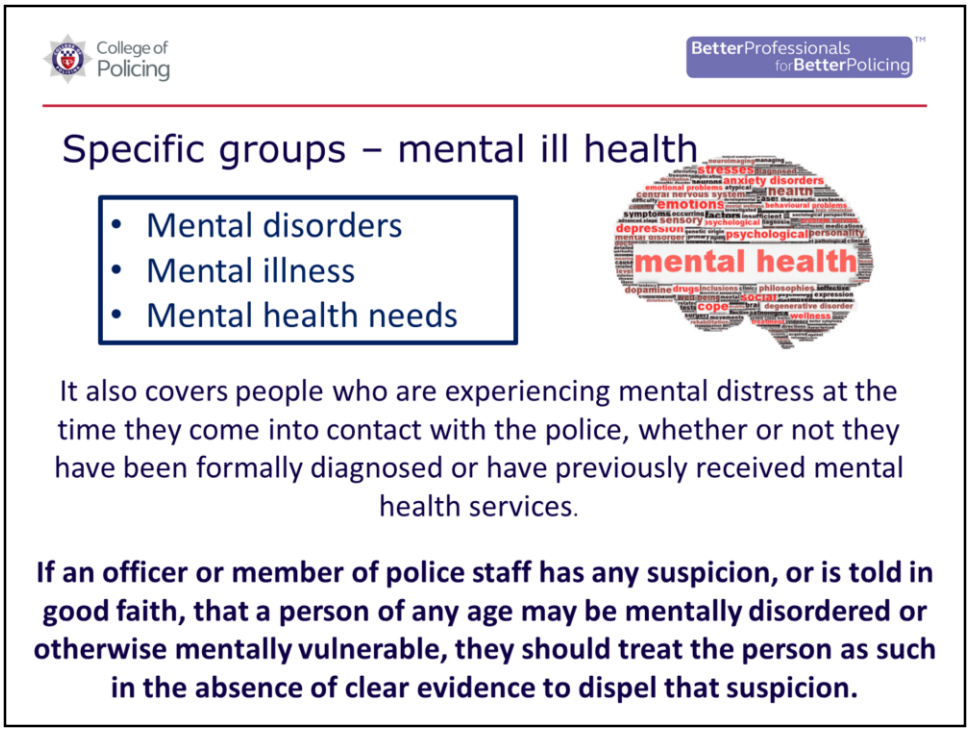
- crowd dynamics and peer group pressure
- environments where communication is difficult
- sensory impairment or communication difficulties, for example, hearing impairment or where the subject may have difficulty in understanding or communicating in English
- the effects of drugs or alcohol
- subjects whose movements are impaired or exaggerated by reason of a medical condition
- subjects who have learning difficulties

https://www.app.college.police.uk/app-content/armed-policing/armed-deployment/#environmental-and-behavioural-influencers



This list is not exhaustive and each group is covered in more detail on the following slides.

Mental ill health, mentally vulnerable, mental health crisis, learning disability, learning difficulties and neuro-disabilities, and autism are all recognised within mental health APP https://www.app.college.police.uk/app-content/mental-health/introduction-and-strategic-considerations/



The term mental ill health is used broadly to refer to all those matters relating to mental health problems. These include mental disorders, mental illness, mental health needs and many of the issues that fall within the MHA 1983 definition of mental disorder and the Police and Criminal Evidence Act 1984 (PACE) Code C definition of mentally vulnerable.

It also covers people who are experiencing mental distress at the time they come into contact with the police, whether or not they have been formally diagnosed or have previously received mental health services.

If an officer or member of police staff has any suspicion, or is told in good faith, that a person of any age may be mentally disordered or otherwise mentally vulnerable, they should treat the person as such in the absence of clear evidence to dispel that suspicion.

** Link to APP location 88

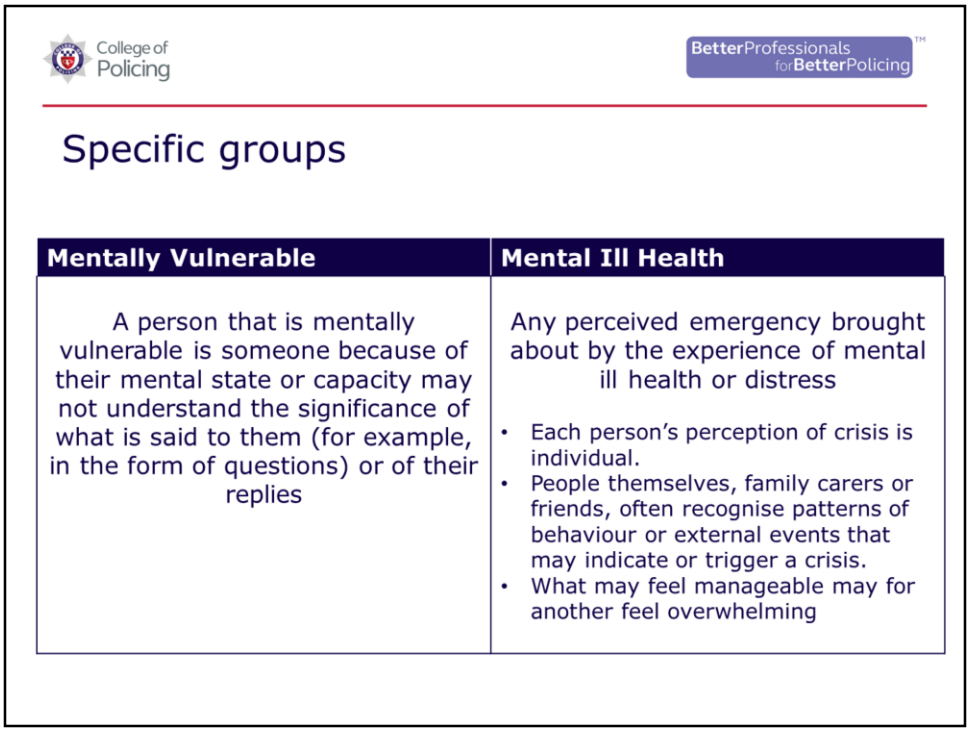
Mentally Vulnerable

A person that is mentally vulnerable is someone because of their mental state or capacity may not understand the significance of what is said to them (for example, in the form of questions) or of their replies.

This is an important consideration when dealing with a mentally vulnerable subject in a use of force context.

(APP Detention and Custody> Detainee Care> 2 Mentally Vulnerable)

(APP Mental Health): https://www.app.college.police.uk/app-content/mental-health/?s=



Mentally Vulnerable

A person that is mentally vulnerable is someone because of their mental state or capacity may not understand the significance of what is said to them (for example, in the form of questions) or of their replies.

This is an important consideration when dealing with a mentally vulnerable subject in a use of force context.

(APP Detention and Custody> Detainee Care> 2 Mentally Vulnerable)

Mental Health Crisis

In the mental health APP module, the term 'mental health crisis' is used to describe any perceived emergency brought about by the experience of mental ill health or distress. There is no legal definition of this term and a person's perception of a crisis is specific to them. Any police decision to describe an incident as a mental health crisis should be based on all available information, and action resulting from any such decision should be guided by the National Decision Model.

The Joint Commissioning Panel for Mental Health has provided more information on defining mental health crisis.

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Specific groups

Persons who are emotionally or mentally distressed	Learning disabilities
"an individual who may behave in an unexpected, extreme or challenging manner as a result of a mental health issue, or emotional distress"	'A state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning' 

Persons who are emotionally or mentally distressed

The term emotionally or mentally distressed (EMD) is used to describe individuals who may behave in an unexpected, extreme or challenging manner as a result of a mental health issue, or emotional distress.

The fact that the subject is EMD does not in any way reduce the harm they may cause to themselves or others if the incident is not resolved. However, officers must be aware that an inappropriate or disproportionate response to someone experiencing EMD could, itself, escalate the situation, causing greater harm to the subject or to others.

Individuals who are EMD may respond to the arrival of armed officers and Taser users in an unexpected or unpredictable manner. This can be caused by a range of factors, for example, mental ill health or extreme distress, which may on occasions be aggravated or caused by drugs or alcohol, or the absence of prescribed medication. Failure to recognise and understand why someone may not be complying with instructions or communication could increase the tension of a situation.

Negotiators, AFOs and Taser users must have an understanding of how EMD individuals may respond to their presence and any visual or verbal contact made with them.

Officers should also consider how their language and tactics could be

interpreted. When dealing with EMD individuals, it can be difficult to predict potential behaviour or responses to any given visual or verbal stimuli.

(APP Armed Policing> Armed Deployments> 4.3 Dealing with Individuals who are emotionally and Mentally Distressed)

Learning disabilities

Section 1(4) of the Mental Health Act 1983 defines a learning disability as 'a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning'.

In general, a learning disability is a condition that affects learning and intelligence across all areas of life.

A learning disability may be mild, moderate or severe and affects the way a person learns and communicates. It may result in a reduced ability to learn new skills, adapt to and cope with everyday demands, understand complex information or, in some cases, to live independently. Those with mild learning disabilities may not receive any formal support and their needs and disability may not be obvious. They may not have had their disability identified before contact with the police. Other people have profound and multiple learning disabilities and their needs may be considerable.

Some people may have physical characteristics that may help identify a learning disability, eg, people with Down's syndrome (which is classed as a learning disability).

J3.1 Dealing with Vulnerable People

Learning outcomes

1. Discuss factors to consider when dealing with vulnerable people.
2. Discuss dealing with vulnerable persons and specific risk factors.

Content

1. Risk factors
2. Vulnerable people
3. Environmental and behavioural influencers
4. Persons who are emotionally or mentally distressed
5. Subjects provoking a use of force
6. Medical conditions
7. Physical disability
8. Communications issues
9. Mental vulnerability and illness
10. Children and young people
11. Communication and defusing strategy

J3.1 Dealing with Vulnerable People

Content 1

Risk factors

There are a number of factors which may influence the operational use of CEDs. These include, but are not limited to:

- head injuries from unsupported falls
- repeated and/or prolonged application of discharge
- avoidance of sensitive areas (primarily head, neck or genitalia)
- pre-existing medical conditions
- positional asphyxia
- subjects already restrained
- acute behavioural disturbance/excited delirium
- vulnerable people
- children and people of small stature
- flammable material (e.g. petrol, CS irritant spray)
- explosive environments (e.g. petrol vapour, propane, natural gas).

These risk factors have been identified from operational experience, medical evaluation and the manufacturer's guidance.

Scenario based training in the use of CEDs is conducted in a way that emphasises the precautions and considerations relevant to the risk factors above.

Further information:

- Detainees requiring urgent medical attention
- Use of Taser conducted energy device in custody
- Monitoring after Taser discharge
- DOMILL, Statement on the Medical Implications of Use of the Taser X26 and M26 Less-Lethal Systems on Children and Vulnerable Adults
- SACMILL, Statement on the Medical Implications of Use of the Taser X2 Conducted Energy Device System

The risk factors listed above are covered in detail within Modules J4 and J5, and as agreed prior learning forming part of the officer safety training programme.

The risk factors shown below are covered within this unit:

- vulnerable people
- pre-existing medical conditions
- children and people of small stature

These risk factors are identified from operational experience, medical evaluation and manufacturer's guidance.

SACMILL has highlighted a risk of heart rhythm disturbance from CED discharge applied to the frontal chest over the heart. This risk may be higher in young or thin people because the heart is nearer to the chest wall (and nearer to the CED probe). If this disturbance occurs, the blood-pumping action of the heart may be reduced during the application of discharge and the person may faint. The shorter the duration of the discharge, the less likely that fainting will occur. Should a heart rhythm disturbance occur, it is more likely to have a detrimental effect in people

who have an existing heart condition or who are intoxicated with certain drugs (including alcohol).

Content 2

Vulnerable people

The police response to all incidents supports the service's commitment to valuing diversity and treating everyone with dignity and respect. People may become vulnerable due to environmental and behavioural influences, or emotional or mental distress. This may include people who are behaving in a manner which suggests they are attempting suicide possibly by provoking the police to shoot them, or to use force against them.

Similar issues may also be relevant when dealing with persons with:

- Medical conditions, such as epilepsy
- Physical disability, such as hearing impairment
- Communication difficulties, such as having a different first language
- Mental illness
- Children

This section seeks to aid recognition of some of these issues so that, where possible, that vulnerability can be reduced and an appropriate response provided.

Whilst it is recognised that officers may have had training in dealing with vulnerable people, either as authorised firearms officers from the National Police Firearms Training Curriculum, or from the Personal Safety Programme, it should be recognised there are particular issues concerning a person's vulnerability and CED consideration and use. Therefore the delivery of this content in context with Taser use is mandated.

Content 3

Environmental and behavioural influencers

Environmental and behavioural influencers (EBI) can affect a subject's behaviour and their response to any contact with police officers. These influencers (sometimes referred to as moderators) can include issues such as:

- crowd dynamics and peer group pressure
- environments where communication is difficult
- sensory impairment or communication difficulties, for example, hearing impairment, or where the subject may have difficulty in understanding or communicating in English
- the effects of drugs or alcohol
- subjects whose movements are impaired or exaggerated by reason of a medical condition
- subjects who have learning difficulties

Content 4

Persons who are emotionally or mentally distressed

The term emotionally or mentally distressed (EMD) is used to describe individuals who may behave in an unexpected, extreme or challenging manner as a result of a mental health issue, or emotional distress.

The fact that the subject is EMD does not in any way reduce the harm they may cause to themselves or others if the incident is not resolved. However, officers must be aware that an inappropriate or disproportionate response to someone experiencing EMD could, itself, escalate the situation, causing greater harm to the subject or to others.

Individuals who are EMD may respond to the arrival of armed officers and Taser users in an unexpected or unpredictable manner. This can be caused by a range of factors, for example, mental ill health or extreme distress, which may on occasions be aggravated or caused by drugs or alcohol, or the absence of prescribed medication. Failure to recognise and understand why someone may not be complying with instructions or communication could increase the tension of a situation.

Negotiators, AFOs and Taser users must have an understanding of how EMD individuals may respond to their presence and any visual or verbal contact made with them.

Officers should also consider how their language and tactics could be interpreted. When dealing with EMD individuals, it can be difficult to predict potential behaviour or responses to any given visual or verbal stimuli.

(APP Armed Policing> Armed Deployments> 4.3 Dealing with Individuals who are emotionally and Mentally Distressed)

Indicators of emotional or mental distress

Awareness of the factors that may indicate whether an individual is experiencing EMD can improve the identification, management and monitoring of any potential risk posed either to or by the subject. They include:

- Previous history, for example, violence, self-harm, suicide attempts;
- Alcohol or drugs consumed or present;
- Recent negative life event, e.g., divorce, separation, bereavement;
- Diagnosis of schizophrenia;
- Depression;
- Experiencing a psychotic episode or crisis, including hearing voices, or auditory, visual or sensory hallucinations;
- Experiencing delusions or feelings of paranoia or of being controlled by others;
- Preoccupation with violence and/or violent fantasies;
- Extreme agitation and excitement, particularly if escalating;
- Apparent difficulty understanding and cooperating with instructions;
- Impulsive or unpredictable emotions or behaviour;
- Repetitive threats, especially if specific or focused;
- Apparent lack of awareness of severity of the situation and potential risks;
- Statements of intent to self-harm or die by suicide.

These indicators are purely a guide and cannot be guaranteed to establish, either by their presence or absence, to what extent an individual is experiencing EMD and exactly how a Taser user should respond.

Assessment of the threat, posed both by the subject and to the subject, within any given crisis situation is a continuous dynamic process within the national decision model (NDM).

(APP Armed Policing> Armed Deployments> 4.3.1 Indicators of Emotional and Mental Distress)

Content 9

Mental vulnerability and illness

Early police recognition of the possible mental health problems, learning disabilities or suicidal intent of people they come into contact with is crucial to ensuring an appropriate and effective response. This is true whether the matter requires a criminal justice response, a social or healthcare response or a combined response. This section of guidance examines the process of identifying and assessing the vulnerability of an individual who has come to police attention.

(APP> Mental health> mental vulnerability and illness)

Learning disabilities

If an officer or member of staff believes that an individual may have some form of learning disability or communication difficulty, the following tips may help improve communication:

- use short sentences using simple language and avoid jargon
- break information into smaller chunks so that one idea or concept is explained at a time – for example, if arrested, explain one at a time who can be considered as an appropriate adult rather than read out the list
- pause frequently, so as not to overload the person with words
- allow time to make sure that the person has understood, and recheck the person understands you – for example**, 'Can you tell me what I have just said so I know I have explained it properly?'** (be aware that learning disabled people may have stronger receptive (understanding) communication skills than expressive skills, and a person's expressive speech may sometimes give an impression of better comprehension than is actually the case, so check their understanding)
- if it is a busy environment with many distractions, consider moving to a quieter location as some people may find it hard to concentrate in such a busy place
- when trying to explain something, such as the advantages and disadvantages of an intervention, using visual aids can be effective – it may also help to offer a photo or drawing to support understanding (for more information on this see the Foundation for People with Learning Disabilities 'Making information easier to read' fact sheet).

De-escalation

De-escalation is an approach and range of tactics that may be used by the police or other professionals to calm an agitated individual to reduce or prevent the use of force or restraint.

Verbal de-escalation and containing a disturbed or confused and vulnerable person in a calm, ideally familiar, and closed environment may be safer and less traumatic for the individual. It may reduce the need for physical restraint and sectioning.

Practitioner experience suggests that, where possible, officers and professionals should maximise the time and space provided so that an individual is offered every opportunity to calm down.

Failure to listen and actively engage in dialogue to draw out an explanation for apparently aggressive or odd behaviour represents a missed opportunity to de-escalate and resolve a situation informally before arrest and restraint may be necessary. An individual who is frightened, confused or injured may appear to be experiencing mental illness, but this should not be assumed before the subject has had a good opportunity to explain what is going on.

De-escalation and communication training

The use of force (including restraint tactics) is only legal and appropriate when it is absolutely necessary in the circumstances and proportionate to the threat and risks posed to the safety of all concerned. Police Mental Health training and Personal safety training includes emphasis on communicating effectively and using de-escalation tactics.

Research into using a US crisis intervention team (CIT) training programme found that officers felt it was important to communicate with people who appear to be experiencing mental health crisis in a patient and empathetic manner. They also felt it important to use verbal and non-verbal de-escalation techniques in order to put people at ease (Hanafi 2008). Another study found that US officers who received CIT training perceived non-physical actions (eg, issuing verbal commands, negotiating with a suspect) as more effective than physical force, especially in response to an escalating mental health crisis scenario (Compton et al 2011).

Police Mental Health training resources, the Personal safety manual and associated personal safety training resources are available via the College of Policing Managed Learning Environment.

Providing reassurance

When interacting with people with communication difficulties, the police should provide reassurance and information about what is happening and why. They should also provide clear information about the person's rights in the particular situation (for example 'easy read' rights and entitlements documentation). This may help to alleviate some of the concerns and anxiety people often feel, whether as a victim, a suspect or someone detained under section 135 or section 136 MHA 1983.

Asking the right questions and terminology

Unfortunately, mental ill health and disabilities often carry an associated stigma. This may present a barrier to effective communication and cause people to feel less able to provide information to the police or others about their health needs.

Officers and staff should be careful in choosing the terminology they use to describe mental ill health or learning disabilities to avoid causing offence and distress. They should be willing to take advice from other agencies on this matter.

The National Autistic Society proposes that officers ask questions such as: 'Do you have any difficulties that I may not be aware of?' if an officer 'has any suspicion, or is told in good faith, that a person of any age may be mentally disordered or mentally vulnerable' ('mentally disordered' is defined in the Police and Criminal Evidence Act 1984 Code C (1) (1.4).)

People with mental ill health or vulnerabilities should not be referred to using their illness as a label. For example, referring to someone as a 'schizophrenic' instead of a person first is negative and dehumanising.

Officers and staff should also understand that misinterpretation can cause anxiety and mistrust that increases risk. For example, some people with autism might take certain common sayings literally. Saying 'it will only take a minute', when in reality a process may take longer to complete), might and cause additional anxiety (National Autism Programme Board 2014). Officers and staff should use clear and unambiguous language and regularly check understanding.

Autism

The national autism strategy for England, Think Autism, sets out how public authorities are required to recognise and support people with autism. Although this strategy is primarily directed towards local authorities and NHS organisations, there may be times when it is relevant to the police response to people with autism.

The legal framework for this strategy is set out in the Autism Act 2009, and the National Autistic Society has developed statutory guidance.

The National Autistic Society has also produced a guide for all criminal justice professionals who may come into contact with people on the autism spectrum as victims, witnesses, suspects or offenders. It is based on the experiences of people with autism and those who work with them, and contains real-life examples and personal accounts by professionals.

(APP> Mental health> mental vulnerability and illness> Communication)

Defusing the situation

The following actions can help create opportunities for the subject and officers to have more time and space to defuse the situation:

- Be prepared to back off
- Use of effective cover
- Give space and time if possible
- Early negotiation
- Evacuate immediate area

This may enable:

- tension to be diffused
- officers to have more time to assess the person's vulnerability
- the effects of alcohol or drugs to wear off
- positive communication and contact to be established
- the level of mental or emotional distress to decrease.

This may result in more positive and constructive communication with the subject, allowing the situation to be dealt with in a controlled manner.

(APP Armed Policing> Armed Deployments> 4.2.4 Defusing the Situation)