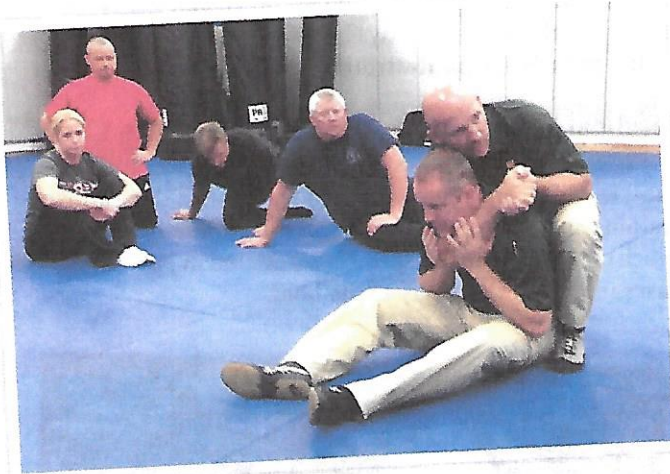


FORENSIC FORCE® SERIES:

The Return of the Carotid Restraint Control Hold

RON MARTINELLI, PH.D., BCFT, CFA, CLS



Law enforcement is experiencing a dramatic increase in citizen contacts and critical incidents involving violently resistive and or otherwise dangerous subjects who are under the influence of street stimulants and designer drugs such as “bath salts.” Officers are also encountering emotionally disturbed persons (EDPs), who are presenting with decompensating, agitated and chaotic behavior and are experiencing serious medical emergencies such as an “agitated chaotic event” and/or agitated-excited delirium.

Whether the subject officers contact is aggressive and violently resistive or experiencing a serious medical emergency, they will need to quickly and efficiently capture, control and restrain the subject for purposes of arrest or medical/mental health treatment. Frequently, such encounters result in multiple applications of an electronic control weapon (ECW), OC spray, impact weapons, and officer swarms to physically control and restrain resisting subjects who classically demonstrate superhuman strength. Occasionally and unfortunately, such encounters can result in a critical incident in-custody death (ICD) of the restrained subject. The resultant ICD more often than not initiates a plaintiff’s federal or state tort claim alleging wrongful death, excessive

force and violations of civil rights that can take years to resolve. Defending against such lawsuits can cost millions of dollars in legal fees, settlements and jury awards for the involved agency.

Millennium Generation and even veteran officers who are often hesitant to go hands-on with an agitated or actively resistant subject often go right to the application of an ECW. However, for a variety of reasons, ECWs are historically only 60% effective in the field. If the ECW is fired at close range, which is often the case, a narrow spread of wired probes is insufficient to create the neuromuscular incapacitation (NMI) needed to incapacitate, capture, control and restrain the resistive subject. Officers who then resort to multiple applications of a “drive-stun” make a serious tactical error against pain-resistant EDPs and agitated-chaotic and or drug-influenced subjects, who feel no pain from the device. Officers now finding themselves in close proximity to the actively resistant subject cannot use their impact weapons for obvious reasons. So what next when seconds matter? Consider the Carotid Restraint Control Hold.

The Carotid Restraint Control Hold (CRCH) offers peace officers a viable method for controlling subjects when other force options may not be justified, effective or available.

History of Neck Restraints

Effective neck restraint holds have been used for hundreds of years by warriors and martial artists and during the past 40 years by law enforcement officers. Prior to the 17th century, Shaolin monks incorporated “vital points” techniques into existing kung fu and wushu arts. Later, “shime-wasa” constricting neck-hold

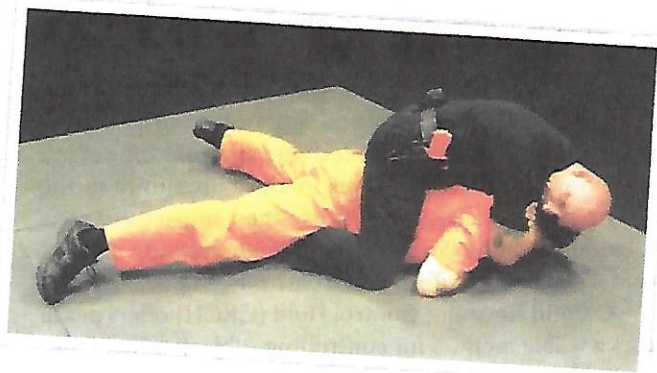


techniques were refined in Japanese ju-jitsu. In 1882, Professor Jigoro Kano developed the art of judo, which included shime-wasa techniques. Many soldiers serving in the Pacific theater during WWII became exposed to judo and other martial arts. In the 1960s and 1970s, judo and ju-jitsu techniques were introduced to law enforcement training. As defensive tactics force options have evolved, some traditional martial arts techniques such as bilateral vascular “sleeper” holds have been demonstrated by DT instructors.

Why Use the Carotid Restraint Control Hold?

The CRCH is a valuable force option that does not rely upon pain compliance, blunt-force trauma, or multiple applications of electronic energy (referred to as “load”) from electronic weapons. When applied by a competent end user, the hold is quick and highly effective and is absent of any evidence of traumatic injury. The hold is more readily accepted by the general public, who are used to seeing mixed martial arts competition.

The CRCH is very effective in controlling EDPs and subjects experiencing an agitated-chaotic event or presenting with excited delirium because the hold generates a painless unconscious state within seven to 10 seconds. The ability to quickly and efficiently render an agitated-chaotic subject unconscious significantly minimizes the risk of in-custody death that often results from prolonged struggles, as well as the physiological exhaustion and cardiac stress created by multiple applications of other force options. The psycho-



physiological dynamic of Pain-Panic Escape Response (PER) normally associated with ECW drive-stuns and body compression upon the resisting subject is also greatly reduced.

Respiratory Versus Vascular Restraint Holds

There are two types of neck restraint holds: respiratory and vascular. A respiratory neck restraint uses direct mechanical compression or pressure over the anterior (front) structures of the neck. This pressure causes asphyxiation by compressing the trachea and restricting the person's ability to breathe. This type of hold should never be used by law enforcement unless lethal force is justified.

A vascular neck restraint employs bilateral compression of the carotid arteries and jugular veins at the sides of the neck that results in diminished cerebral cortex circulation. This

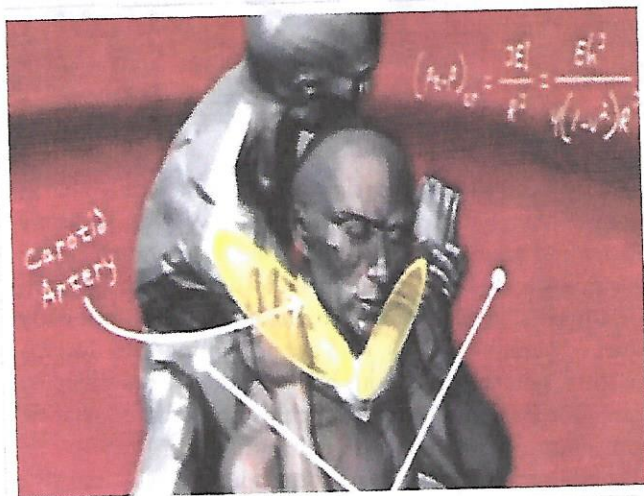
abrupt reduction of blood significantly affects the ability of the cerebral cortex to remain in an “awake state” and leads to unconsciousness.

It is very important for end-user officers, law enforcement administrators and the media to understand that when applying a **vascular neck restraint**, no significant frontal pressure or compression is applied to the delicate structures of the front of the neck. This means that if the restraint is properly applied, the restrained subject should be free of unreasonable pressure to the front and rear of the neck that might cause secondary injuries or death. Equally important is that the subject also retains their ability to breathe. The CRCH is a vascular neck restraint.

Sloppy or uninformed terminology and casual reference by any individual to vascular neck restraints as a choke hold, a strangle hold, a neck hold or “choking the subject out” serves only to confuse the goal of the restraint, the physiology behind it and the desired outcome. Again, the **vascular neck restraint** should always be referred to by this term, or by the term “**Carotid Restraint Control Hold**.”

Medical Studies Support the Use of the CRCH

Recent medical studies and opinions support the use of the CRCH by competent officer end users with standardized training and technique. These studies have finally put to rest much of the nonforensic speculation offered in past litigation cases regarding the safety of the hold.



Medical experts from the Canadian Police Research Centre's *National Study on Neck Restraints in Policing* opined, “While no restraint methodology is completely risk free, there is no medical reason to expect grievous bodily harm or death following the correct application of the vascular neck restraint in the general public by professional police officers with standardized training and technique.”

Dr. John Pi, M.D., a board-certified emergency medicine physician who is currently an associate clinical professor

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CAROTID RESTRAINT CONTROL HOLD

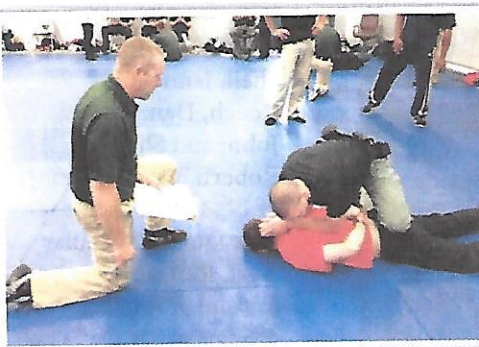
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at UCLA's School of Medicine, as well as the Tactical Medical Director for the Los Angeles Tactical Medical Program and a 14-year veteran agent of the FBI, has stated, "When properly applied, BVR (bilateral vascular restraint) is effective and safe and can minimize injuries to subjects, bystanders and officers."

Pros and Cons of Using the CRCH as a Force Option

As with any police use-of-force incident, the type of force, quantum of force and manner in which the force is applied are always subject to legal guidelines and public scrutiny. The CRCH must be used in a reasonable manner as set forth in current case law, state laws, federal law and department policy.

Pros: The CRCH offers an alternative to lethal force, repeated uses of ECWs, impact weapons, OC spray, personal body weapons and excessive body compression during officer swarms. The hold is effective for officers of all sizes and strengths.



The hold can be effectively applied and control can be gained upon combative individuals who demonstrate a high tolerance for pain, are under the influence of drugs and/or are in an excited, agitated and/or psychotic state. Application of the hold does not appear violent or excessive and is less likely to create a negative public perception. The CRCH can reduce officer injuries as well as serious injuries to subjects and potential for in-custody death by providing an additional force option that does not rely upon electrical load, pain or blunt-force trauma to gain control of the individual. As stated, recent medical research concludes that the hold is "unlikely to result in serious injury or death" when applied properly by competently trained end-user officers.

Cons: The CRCH requires officers to be in close proximity to the resistive subject. This means that the officer's weapons are also in close proximity. However, this is a normal risk anytime officers struggle to restrain any resistive subject. As with any other force option, the CRCH technique requires recurring training to maintain proficiency to ensure that both the application and post-application are properly followed. A medical clearance should be obtained each time the hold is applied.

Where Should the CRCH Be Placed as a Force Option?

Based upon how the CRCH is applied, when it should be applied and the desired effect of generating unconsciousness if the resisting subject does not submit to arrest, CRCH instructors and police practices experts like me suggest that the hold should be classified as an "intermediate level" of force along with ECWs, impact weapons and personal body weapon strikes.

Training and Certification in the CRCH

The CRCH is a force option in itself, with its own inherent risks. Initial

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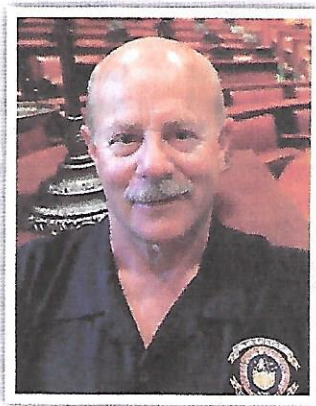
certification training of end-user officers, mandated periodic update training and updated policies and procedures are paramount for agencies authorizing this very practical, much-needed and unique use-of-force option.

One training resource I have found that provides excellent instructor certification training and policy consultation is the Carotid Restraint Training Institute (CRTI), located in Riverside, California. It can be found online at www.CarotidRestraint.com.

Be safe out there!

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About the Author

Ron Martinelli, Ph.D., is a former police officer and detective with over 22 years of street experience. Dr. Martinelli is a multicertified use-of-force instructor who also is a forensic criminologist and police practices expert specializing in officer-involved shootings and major uses of force. He is NCCM Board Certified in Forensic Trauma, a Diplomat with the Academy of Experts in Traumatic Stress, a Certified Force Analyst with the Force Science Center and a recognized member of the American College of Forensic Experts Institute. Dr. Martinelli is nationally recognized for his research on the subject of psychophysiology and stress-induced responses. He can be reached at (951) 719-1450 and at Code3Law@martinelliandassoc.com. ☆

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