

Examining the liability issues associated with prone restraint deaths in detention

Abstract

During a period of confinement in a detention facility, it is not uncommon for detention officers to confront a violent and combative detainee. While rare, a detainee may unexpectedly die during or after the control and restraint process and from being restrained in the prone position. Following a custodial death, a lawsuit will most likely be filed claiming that the responding officers used excessive force and that it contributed to the positional asphyxia death of the detainee. Further, the lawsuit may assert that the administrator failed to train and supervise the officers and failed to implement constitutional policies and procedures. The medical issues associated with prone restraint and the excessive force litigation theories have emerged as a high profile subject in detention liability. This assessment examines the current status of the scientific research performed on prone restraint and provides an assessment of the outcomes and trends in the lower court's decisions regarding a custodial death after the use of the prone restraint position. Recommendations for detention administrators are also discussed.

Keywords: use of force in detention, force liability, positional asphyxia, in-custody deaths

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Introduction

The job of working in a detention facility is both dangerous and stressful. Detention officers interact daily with a diverse detainee population and are authorized to make decisions about the lives of those confined. Detention officials are presented with significant challenges as they confine a mixture of pre-trial detainees, convicted prisoners, female and males, youthful offenders, and experience a high turnover of the detainee population, creating a chaotic environment. From 1978 to 2015, an average of ten million detainees were admitted into the nation's detention facilities.¹ Of these detainees, it estimated that about 40% were admitted with a variety of chronic medical conditions, 63% were admitted with a history of drug dependence or abuse, and 40% of these detainees were using drugs at the time of the offense.² The most common abused drug was marijuana, followed by cocaine, and crack cocaine. Further, about 26% of the admitted detainees were diagnosed with a serious mental health condition and 29% were confined for committing a violent crime.³ While confined, 10% of these detainees incurred a disciplinary report for assaulting another detainee or correction officer.

Tasked with balancing the need to maintain internal facility security and ensuring their own personal safety, officers also are responsible for protecting a detainee's constitutional rights and properly implementing policies and procedures of the facility. In *Turner v. Safley*⁴ and in *Florence v. Board of Chosen Freeholders of County of Burlington*⁵ the United States Supreme Court reflected that running a prison (jail) is a difficult task and allowance for wide range of substantive discretion to ensuring safety of those confined and the officers who work there should be afforded to correctional officials. Hence, courts consider the practical importance of taking into account the safety issues of those managing and working in the jail and the objective reasonableness standard provides deference to implementing policies and practices to ensure internal security of the jail is maintained.

Recognizing the safety risks posed from working in a detention facility, the Court acknowledged in order to achieve this balance

detention officers have been authorized authority to use force. The United States Supreme Court in *Kingsley v. Hendrickson*⁶ established that claims of excessive force are assessed by using the objective reasonableness standard. The Court opined that frequently officers must make decisions to use force under dangerous, tense, and rapidly evolving situations, and without the luxury of deliberation or a second chance. The Court ruled that officers often confront encounters where they must make split-second decisions about the type and degree of force to use in a given situation. In examining a claim of excessive force, the degree and type of force used is analyzed from the perspective and knowledge of the officer. Liability attaches only if the excessive force was deemed to be unreasonable based on the totality of the circumstances facing the officer at the time. Further, the United States Supreme Court ruled in *Mullenix v. Luna*⁷ and reemphasized in *Kisela v. Hughes*⁸ that use of force is an area of the law in which the result depends very much on the facts of each case and thus police [officers] are entitled to qualified immunity unless existing precedent squarely governs the specific facts at issue.

With some frequency, detention officers confront a violent and combative detainee exhibiting behaviors consistent with a drug-induced state of agitation or agitation and violence from a detainee who is mentally impaired requiring control and restraint. Ross⁹ reported that about 50% of the violent restraint incidents involved either a detainee who is either mentally ill or is under the influence of a chemical substance. In about 78% of those incidents, the confrontation occurred in the booking area, in a cell during a force cell extraction or during a cell transfer, and the recreational/dayroom areas.

Detention officers have at their disposal a variety of empty-hand control measures, non-deadly force equipment including the TASER, aerosols, projectiles, and canines. Additionally, officers have access and may apply various types of restraint equipment, including: handcuffs, leg restraints, flex-cuffs, restraint belts, and the restraint chair. With a high frequency of use, a combative detainee will commonly be placed on the floor in the prone control and restraint position and restrained in handcuffs (placed on their stomach). If the detainee continues to resist by kicking his or her legs, the ankles

may also be restrained with leg restraints. While uncommon, in some restraint incidents the once violent, actively struggling, and restrained detainee becomes unresponsive requiring medical attention. Efforts to revive the detainee by the officers or medical personnel are unsuccessful, whereupon it is determined that the detainee is dead all within a short amount of time after the process of control and restraint. An autopsy may not reveal anatomic and toxicological results sufficient to explain the death. In many of these death incidents the pathologist is left to theorize that the detainee died from their underlying medical condition, drug, or mental health condition, or all three. The pathologist may also conclude that the detainee died as a result of the detention officers use of force measures, including being controlled and restrained in the prone position, which caused or contributed to positional, restraint, or compressive asphyxia. Regardless of whether the pathologist classifies the death as natural, a homicide, an accident, or undetermined, the estate of the detainee will generally file a wrongful death excessive force lawsuit against the responding officers, the jail administrator, the sheriff, and county administrators.

There is a societal interest in guiding detention officers towards the safest and effective method of controlling and restraining combative detainees. A sudden restraint death in custody presents a controversial issue containing many complexities within the incident. At the core of these cases are the associated medical and the liability issues which emerge. Researchers have been studying the associated medical issues which may be associated with prone restraint deaths and have published their findings for several years. In their collective totality, the reputable scientific research to date reveals that the prone restraint position is the preferred and safe position to employ when restraining a violent detainee or arrestee. Yet, despite the current status of the scientific research, cases are litigated, which have created varying liability trends by the lower courts' application of qualified immunity and the application of use of force law. The medical issues associated with prone restraint and the theories of excessive force litigation have become an important subject area in detention liability. Hence, this article will provide an overview of the frequency of a sudden death in detention, an overview of the scientific research on prone restraint, and followed by a discussion of the lower court's decisions and their trends. Finally, recommendations for detention administrators are detailed.

Frequency of a sudden restraint death

Custodial deaths in a detention facility are rare, let alone a sudden death after the use of the prone restraint position. Researchers from the Bureau of Justice Statistics, a unit of the Department of Justice, reports on deaths in detention facilities but deaths resulting from the use of force and restraints are not specifically reported. Noonan¹⁰ reported that from 2000 to 2014 a total of 14,786 deaths occurred in detention facilities nationwide. About 35% of these detainees were confined for a violent offense. Over the period the causes of these deaths included: illness represented 51% (i.e., heart disease, aids, cancer, respiratory, liver disease, and other illness); suicides accounted for 31%; drug/alcohol accounted for 7%; accidents accounted for 3%; homicide accounted for 2%; and other/unknown and missing accounted for 3%.

Zeng¹ reported that from 2000 to 2014, the average daily population of detainees in detention facilities was about 740,000 detainees. During the period, an average of 986 detainees died annually from any cause of death. Using these estimates, the likelihood of a detainee death while confined in a detention facility is about 0.013%. Noonan¹⁰ reported that deaths from homicides (2%) include detainee

on detainee assaults, the use of force incidental to staff use of force, and also from assaults sustained prior to confinement. Taking a liberal estimate, a sudden death resulting from the use of the prone restraint position may account for about 1% (n=172) of the total reported deaths. The likelihood that a custodial death resulting from using the prone restraint position equals about a 0.0002% chance probability. The mortality data shows that the likelihood of a detainee custodial death resulting from a prone restraint incident is very rare, given the number of detainees admitted and released and given their medical, mental health, and backgrounds for abusing drugs.

Scientific research and prone restraint

Detention officers successfully use the prone restraint position frequently with combative detainees annually without the subject sustaining an injury, let alone a death. The prone restraint position is the standard subject control and restraint technique taught in police and correctional academies and taught at departments through in-service training courses. The notion that placing a combative person in the prone position to control them causes asphyxia is unsupported by the scientific research. Research has shown that the prone position is not a dangerous position to control and restrain a combative detainee.¹¹⁻¹² DiMaio¹³ also reported that the acceptance of the concept of positional asphyxia as the cause of death in restraint related deaths frequently involves the suspension of common sense and logical thinking.

When a cause of death cannot otherwise be determined, positional asphyxia or compressional asphyxia is often suggested as playing a role in the death. Positional asphyxia can be defined as a form of asphyxia which occurs in individuals who are found in an abnormal body position which prevents adequate gas exchange such as from upper airway obstruction or a limitation in chest wall expansion.¹⁴⁻¹⁵ The term "positional asphyxia" was transferred to "restraint asphyxia," "compressional and/or traumatic asphyxia" and was applied to law enforcement arrest and restraint situations attempting to support the argument that short-term pressure on the back of the arrestee caused on contributed to the person's sudden death. The prone restraint process generally involves one or two officers placing one or both knees on the person's back to assist in the control and restraint of person in handcuffs and/or leg restraints. The theory suggests that whenever the person is restrained and dies, positional or restraint asphyxia is the primary cause of death regardless of the presence of other physiological and/or psychological symptoms and conditions. Proponents of this theory hypothesized that an arrestee restrained prone and hobbled and/or hogtied (restrained on their stomach with hands and wrists secured to the handcuffs) were unable to breathe because the position caused chest wall and abdominal restriction that prevented adequate expansion of the lungs and subsequently led to asphyxiation.¹⁶ Part of the argument is not only that the position is dangerous but the weight placed on the person's back by the restraining officers assists in applying excessive weight on the back, compromising ventilation, leading to asphyxiation. Hence, the theory supported the argument that placing a violent person in the prone position created a deleterious risk of harm to the arrestee.

Researchers, however, using sophisticated measurement have refuted the positional or restraint asphyxia hypothesis.¹⁷⁻²² These researchers have found that being placed and restrained in the prone position does not produce physiological respiratory compromise. The prone position is the preferred position used when attempting to control and restrain a combative detainee.²³ Additional reputable scientific human subject studies conducted on prone restraint confirms that using the prone restraint position and/or the maximally restrained

position with a combative subject does not cause an alteration in the amount of oxygen in an individual's blood, which is the requirement necessary for asphyxia to occur, nor does it restrict ventilation nor compromises respiratory function.²⁴⁻²⁵

Other researchers have also studied prone positioning of obese subjects and found that prone positioning did not cause respiratory compromise.²⁶⁻²⁷ Human subject research studies have also shown that weight force while restrained did not produce evidence of hypoxia or hypoventilation indicating a risk of asphyxiation or life-threatening abnormalities in ventilation.²⁸⁻²⁹ Moreover, Kroll, Still, Neuman, Graham, & Griffin designed a biomechanical model to examine the force necessary to cause rib fractures resulting in flail chest (compressional asphyxia).³⁰ The researchers found it would take over 626 pounds of pressure on the chest to be fatal. Through the model, they determined that it would take two 285-pound officers balanced perfectly on the chest for a period of time of a resisting subject to produce compression asphyxia. Additionally, Kroll, Brave, Kliest, Ritter, Ross, & Karch measured the weight force of placing one or two knees on a Simulaids Rescue Randy training mannequin placed in the prone position, which replicated the prone restraint process.³¹ Respondents placed either one knee on the shoulder blade area of the mannequin or placed one knee on the shoulder blade area and the other knee on the lower back. It was determined that the two-knee method applied slightly more weight than the one knee method. The results of the study found that body weight is irrelevant to prone-weight with the single-knee technique and only a slight influence with two-knees. Both findings were well below a consequential risk level of injury potential. The results show that the use of placing one or two knees on the back during the restraint process is a safe technique and does not support a risk of restraint asphyxia. The findings also support the epidemiological research that has examined the outcome of prone restraint with violent subjects.

Moreover, four independent epidemiological research studies examined the outcomes of violent prone restraint incidents provide greater weight of evidence regarding the safe use of the prone restraint technique than lab experiments. In the first study, Hall, McHale, Kade, Stewart, McCarthy and Flick researched 1,255 arrestees restrained in the prone position by Canadian police officers.³² The majority of the arrestees were male and the use of the prone restraint position was common. The researchers reported that not one arrestee died and that the prone position was not associated with the sudden arrest-related deaths. In the second study, Hall, Votova, Heyd, Walker, MacDonald, Eramian, & Vilke studied over 2,000 prone restraint incidents in police custody in seven Canadian cities.³³ Arrestees were controlled and restrained in the prone position and not one died. The researchers did not find a correlation between prone positioning, death and asphyxiation. Third, Ross and Hazlett studied 1,085 prone restraint arrest incidents with law enforcement officers and showed that the prone restraint position was not related with a risk of asphyxiation or death with violent arrestees who exhibited signs of intoxication, mental illness, and/or drug use, and excited delirium.³⁴ Study findings showed the prone restraint position did not lead to any death and 16 percent sustained a moderate injury, even when intermediate weapons or other force measures were applied prior to or during the restraint of a violent arrestee, when weight was applied on the back of the arrestee, and also when the subject's ankles were restrained from 1 to 5 minutes. Finally, Lasoff, Hall, Bozeman, Chan, Castillo & Vilke also studied 2,431 force incidents, of which 1,535 (63%) subjects were placed in the prone restraint position, and he reported no deaths during the study.³⁵

In these studies, arrestees exhibited co-morbidities of mental illness, drug use, or intoxication, and many demonstrated two of these. In their collective totality, these four studies examined over 5,500 field prone restraint incidents and not one death was reported, despite subjects remaining prone after handcuffing. The laboratory and epidemiological research literature related to the use of the prone restraint does not suggest any specific risk to an arrestee. These four field studies show a robust consensus that the prone restraint position does not cause life threatening changes in pulmonary function. As Karch observed, positional asphyxia as the term is used in court today, is an interesting hypothesis unsupported by any experimental data.¹¹

Focus of litigation claims and restraint asphyxia

Even though the science disputes the theory of restraint or compressional asphyxia during prone restraint of a combative arrestee, incidents of sudden custodial death after the use of force and restraint are still being litigated in court. Science and related liability issues intersect in cases of sudden custodial restraint deaths and involve complex medical and legal issues. The scientific studies on this subject are paramount in assisting the legal parties in assessing any potentially culpability. Numerous issues emerge and generally focus on several broad areas. First, the plaintiff's counsel will claim that the responding officers used excessive force in their use of physical control techniques, the use of any non-deadly force equipment like an aerosol or the TASER, placing the detainee prone on the floor, placing weight on the back of detainee, and the restraints that were used contributed or caused the decedent's death. Medical experts from the plaintiff's perspective will examine the medical and mental health history of the decedent. Further, the medical expert will examine the physiological science of using restraints on combative detainees to support the hypothesis that using the prone restrain position in combination with other force measures contributed to the decedent's death through the restraint asphyxia, regardless of the cause and manner of death. Second, the plaintiff's counsel will claim that the detention facility administrator directed the officers' actions in using force and restraint equipment in accordance with the agency's policies which alleging that they are constitutionally defective. Third, the plaintiff's counsel will claim that the administrator failed to supervise the officers and had prior knowledge that officers chronically acted outside the scope of their authority and agency policy without remediation or termination. Fourth, the plaintiff's counsel will claim that the administrator failed to train the officers in the use of force, in the use of non-deadly force equipment, in failing to train the officers in the hazards of placing combative detainees in the prone restraint position, and failed to train the officers in the proper use of restraints. Fifth, the plaintiff will commonly claim that the officers failed to provide timely medical care to the decedent and/or that detention medical personnel were deliberately indifferent to the medical needs of the decedent. Sixth, in accordance with the Americans with Disabilities Act (ADA) an allegation may also be filed claiming that the agency's policies and actions of the officers failed to accommodate any disabilities of the decedent. Lastly, the plaintiff will claim that the administrator ratified the officer's conduct by not conducting a death investigation or conducting a less than adequate investigation into the incident. As the lawsuit works its way through the litigation process, many claims may be dismissed by the court, but the agency administrator and their defense counsel must be prepared to defend against each one.

Liability issues and restraint asphyxia

In this section a review of selected published § 1983 case decisions

of the lower courts are reviewed. Cases decided prior to the scientific research on the topic are examined (1998), after the scientific research has been published, and after the United State Supreme Court's decision in *Kingsley*. A prone restraint death may occur during police arrest and/or while being restrained in the detention facility. The discussion below primarily examines cases occurring in detention facilities and a few cases which occurred during police arrest.

*Lanzo v. Smith*³⁶ represents one of the first published custodial restraint death court decisions. Lanzo, was a mentally impaired arrestee, struck the arresting officer, fought with other officers, and one officer struck him in the head with a flashlight causing severe injury. During booking at the jail, he started another fight and detention officers used force measures to control him and placed him a padded cell. He was later transported to the hospital and upon returning to the jail he began ramming his head into the cell door. The sheriff instructed the officers to control and restrain him with handcuffs and a security belt, and then placed him in another cell. Days later Lanzo's mental health deteriorated and he began ramming his head into the cell wall. The officers entered the cell, placed him prone on the floor and held him down as kicked his feet and screamed. An officer with medical training entered the cell and observed that Lanzo was not breathing and his skin was turning blue. The officers immediately initiated a heart massage, medical personnel responded, and continued the heart massage, but it was unsuccessful. The autopsy revealed that Lanzo sustained 115 injuries on his body, with a significant number self-initiated by Lanzo. An inquest determined that the death was an accident. Two doctors, however, found that Lanzo died due to traumatic neck injury and asphyxia caused by a headlock applied by one of the officers. The Fifth Circuit affirmed the lower court's decision that the sheriff had not failed to train or supervise his officers. The court however, found that the officers use of force exhibited was potentially excessive and remanded that portion of the case back to the lower court.

In *Owens v. City of Atlanta*³⁷ a detainee was placed in a holding cell at the hospital for his disruptive behaviors stemming from a drunk and disorderly conduct and sustaining injuries during the arrest. While in the cell, the detainee became violent and the officers restrained him in a position known as the "mosses crosses," which crossed his arms in front of him, handcuffed, and secured him to holes in a bench. The detainee's ankles were also stretched and shackled with accompanying legs irons connected to the wall. The stretch hold and restraint position were trained techniques and only used with violent detainees. The detainee lost his balance, fell forward, the officers later discovered him with a weak pulse, and he subsequently died. The pathologist determined that he died of positional asphyxia. The Eleventh Circuit affirmed the lower court's summary judgment in favor of the officers, holding that the restraint method was not inherently dangerous. The court noted that the officers had been trained to use the technique, used it previously, and they had used the technique previously without problem. The Court ruled that the officer's action did not violate the detainee's rights. Further, the Court ruled that the municipality was not deliberately indifferent to the medical needs of the detainee and were not indifferent to the training in the use of the restraint system.

The first published medical research on the issue of prone restraint was performed by Reay et al.¹⁶ Using 10 healthy volunteers, respondents exercised on a stationary Nordic-Track cross-country ski-machine for several minutes in order to elevate their physiological baseline levels. They found that after exercise and being placed in a prone restraint and hog-tied position (arms restrained in handcuffs behind their back,

ankles restrained with leg restraints, and a cord connected to the leg restraints, pulling the feet toward the buttocks and connected to the handcuffs) increased the risk of ventilation was compromised. They found that the restraint position comprised respiration and increased the risk of hypoventilation and hypercapnia. Although none of the healthy volunteers died, the researchers hypothesized that placing a violent arrestee in the prone restraint position would cause "positional asphyxia," leading to a sudden death. Subsequent to this published study, there were several prone restraint incidents which ended in the death of the arrestee or detainee, the cases were litigated, and a majority settled out of court based on the research.

In 1997, Chan et al.,¹⁷ performed experimental human subject research on the use of the prone restraint procedure and their findings contradicted the Reay et al. study. In *Price v County of San Diego, et al.*,³⁸ the court issued its summary judgment decision in favor of the officers based on the Chan et al. research. High on methamphetamine, Price violently fought with responding deputies, they controlled him, restrained him in the hogtied position, he stopped breathing, and he died two days later in the hospital. The estate filed a §1983 lawsuit claiming excessive force and using the prone restrain procedure caused his death from positional asphyxia. One medical examiner found that the restraint position caused his death while another opined that it did not based on the Chan et al. scientific research. Using more sophisticated research instruments with healthy respondents, who exercised on a bicycle ergometer and then placed in the hogtied position, they found that there was no association with any clinically relevant changes in respiratory or ventilatory function with the study respondents. Based on the findings of the research, the court held that in and of itself, the hogtied position did not constitute excessive force when a violent individual has resisted less severe restraint techniques. The court ruled in favor of the defendants and ruled that applying a physiologically neutral restraint procedure that will immobilize him is not excessive force. As discussed earlier, there have been additional human subject research studies performed on the issue of positional and compressional asphyxia, as well as epidemiology studies since the Chan et al. (1997) study affirming their results.

The response to the current research has received mixed results by the courts in prone restraint litigation. Some of the courts apply the research to the fact-based patterns of the case, while some dismiss the research, and some still rely on the debunked Reay et al. study. The following court decisions illustrate some of the trends. In *Giannetti v. Stillwater*³⁹ the Tenth Circuit held that applying force upon the legs, arms, hands, and the back of a handcuffed misdemeanor detainee in the prone position for nearly twenty minutes, resulting in death, was not unreasonable. The detainee was mentally ill and being booked for a minor offense when she refused to put on a jumpsuit as instructed by the officers. She continued to refuse and began to resist the officers, they handcuffed her and placed her on her stomach in order to remove her pantyhose before putting on the jumpsuit. During the twenty minutes the detainee laid prone and multiple officers struggled with her to put the jumpsuit on her. The detainee kicked her legs at the officers and twisted and thrashed her body while the officers held her arms, legs, arms, head, and back down in an effort to keep her from moving. The officers placed her in the figure four position by crossing her legs, bringing her heel of her right leg toward her buttocks, officers placed a knee in the middle of her back, and placed a knee on her shoulder blade. On two occasions she screamed that she could not breathe and that the officers were hurting and killing her. After the officers placed her in the jumpsuit, she became unresponsive, her lips turned blue, and the officers placed her on her back, began CPR,

called for an ambulance, and she did not survive. The autopsy listed asphyxia as one cause of death. The family filed a § 1983 lawsuit claiming excessive force, that she suffocated due to her struggling and kicking against the officers, and the psychological fear that she would die from the inability to breathe. The plaintiff argued that the officers failed to take into account her mental illness. The Court concluded that the officer's use of force was reasonable as the officer's force was only used in response to the detainee's active resistance of struggling and kicking.

In *Hill v. Carroll County of Mississippi*⁴⁰ the Fifth Circuit affirmed the lower court's decision that using the hogtied restraint position with a violent detainee was an objective reasonable use of force. A combative arrestee was transported to the jail in the four-point restraint, handcuffed, legs restrained and connected, and prone. During transport the arrestee became unresponsive unbeknownst to the transporting officer. In the sally port of the jail, a responding detention officer found the arrestee unresponsive and pulseless. The officers immediately began CPR, notified medical personnel, and the officers transported the arrestee to the hospital, where the arrestee died. The autopsy showed that the cause of death was undetermined. However, the detainee was considered obese and hypertensive, the body temperature was recorded at 107.5 degrees F, with fatal hyperthermia, and there were no presence of drugs or alcohol. The coroner ruled out asphyxia but the family's expert pathologist determined that the arrestee died of asphyxia, and the excessive force lawsuit proceeded based on the plaintiff's medical expert's opinion of the cause of cause of death. The plaintiff used a police practices expert who opined that the four-point restraint procedure should never have been used and it was excessive. Also, the plaintiff used a medical expert who opined that the restrained position the detainee was forced to assume caused her death from positional asphyxia. However, the Fifth Circuit rejected both of the expert's opinions. The Court found that even though there may have been other alternatives available to the officers, the use of the four-point restraint procedure was not excessive and was reasonable.

Further, which is instructive regarding the published scientific research, the court found that the plaintiff's medical expert failed to provide necessary scientific evidence countering the research conducted to date and failed to opine on any scientific journal study, including his own, that showed that the four-point restraint is inherently dangerous to arrestees who are not drug abusers or showing that the placing pressure on the hog-tied restrained person was inherently dangerous. The court concluded that the jury could not draw an inference from the published studies that applying the four-point restraint to the decedent was inherently dangerous. The Court also ruled that the officer's use of the restraint position was not unreasonable and was not excessively disproportionate to the resistance they faced. The court further concluded that the officers did not fail to monitor the arrestee and did not act with subjective knowledge of a substantial risk of serious harm and did not act with deliberate indifference to the detainee's medical needs as they initiated CPR, notified medical personnel, and transported the arrestee to the hospital. Further, in numerous other cases the court awarded qualified immunity to the officers finding that the law allows the officers to control a resistant subject prone, even using their body weight, in order to gain control, that the officers use of force and the prone restraint position was reasonable force, that the officers used the restraint process in response to the detainee's resistance, and that when the officers discovered that they detainee was unresponsive they immediately provided access to medical care, and were not found to

be deliberately indifferent to the medical needs of the detainee.⁴¹⁻⁵² However, there have been several court decisions denying summary judgment to the officers in these types of cases.

In *Swans v. City of Lansing*⁵³ the jury found in favor of the estate of a detainee who died in a holding cell. While being booked into the detention center, Swans became violent, kicked a booking sergeant and responding officers used force to control him and attempted to place him in a restraint chair but were unsuccessful. The officers carried him to a holding cell, restrained him in the prone position with his hands restrained in handcuffs behind his back, his legs restrained with a restraint strap, and the officers left the cell. The officers monitored him by closed-circuit television, returned to the cell within ten minutes, and discovered that he was unresponsive. The officers removed the restraints, called for emergency medical services, initiated CPR, and he was transported to the hospital, where he died. The autopsy revealed that Swans died from cardiac dysrhythmia caused by positional asphyxia during custodial restraint. At trial the jury determined that the officers used excessive force, misused the restraints, and that administrators failed to train, supervise, and direct their officers in how to properly respond to and restrain mentally impaired detainees. The jury awarded \$10 million to Swans' estate.

In *Kitchen v. Dallas, County TX*⁵⁴ officers of the emergency response team responded to the cell of a mentally ill detainee who was combative and exhibiting self-injurious behaviors. The officers did not radio for medical personnel and entered the cell and one officer kicked the detainee while another used a neck restraint. The detainee later died allegedly from asphyxia and his widow sued claiming excessive force, a failure to supervise and train the team, and a failure to call medical personnel prior to entering the cell. The court found in favor of the detainee's widow finding that the actions of team members were excessive but rejected the claims of failure to supervise, train, or a failure to contact medical personnel prior to the entering the cell.

In *Estate of Booker v. Gomez*⁵⁵ detainee Booker pulled away from the grip of a female detention officer and nearly struck her in the head during an escort to this cell. Other officers responded and placed the detainee on the floor in the prone position and he began to actively resist the officers. One officer applied a carotid neck restrain on the detainee, while a second officer placed a pain compliance device on the detainee's legs. A third officer placed his knee on the back of the detainee to control the detainee for handcuffing. Once the detainee was secured in handcuffs a fourth officer applied the TASER in the drive stun mode for eight seconds while an officer continued to apply the carotid hold. The officers ceased their use of force, carried the detainee to a cell, did not check his pulse, and exited the cell. Within in about 21 seconds an officer noticed that the detainee was unresponsive, jail medical personnel responded within about 90 seconds, and rescue efforts were unsuccessful. The detainee was transported to the hospital and pronounced dead. The medical examiner determined that the detainee died of asphyxia caused by the detention officers, certified the death as a homicide, and reported that the cause of death was also cardiorespiratory arrest during physical restraint. The detainee's estate filed a §1983 claim alleging that the officers used excessive force, denial of medical care, and a claim against a sergeant for failing to supervise the officers. The Tenth Circuit affirmed the lower court's denial of summary judgment for the county and the officers. Reviewing the claim under the Fourteenth Amendment, the Court concluded that Booker was not resisting and therefore the officers' use of the carotid hold, placing weight on his back, and applying the TASER was constitutionally excessive. The Court reasoned that a

reasonable officer would know that failing to check the pulse of an unconscious detainee or failing to provide medical care after the use of serious force, by using the TASER and applying pressure to the back, amounted to deliberate indifference. In additional case decisions the court also ruled in favor of the plaintiff.⁵⁶⁻⁵⁹

The cases discussed were all decided prior to the United States Supreme Court's decision in the *Kingsley v. Hendrickson*.⁶ For the first time the Court ruled on the use of force involving a pre-trial detainee confined in a detention facility. Transferring the excessive force review criteria established in their decision in *Graham v. Connor*⁶⁰ the Court held that a detainee need only show that a jail officer's use of force was objectively unreasonable in accordance with the Fourteenth Amendment. As well the officer's perception at the moment the officer used force within the totality of circumstances must be evaluated. The lower courts have begun applying the *Kingsley* decision to prone restraint incident litigation.

In *Ryan v. Armstrong*⁶¹ the Eighth Circuit granted summary judgment to jail officers who used force to control a violent mentally ill detainee. The detainee was held in the holding cell on minor offenses, outstanding traffic tickets, and appeared to be under the influence of drugs. While confined in the cell he began to make animal like movements, acting strange, lunging, and banging his head on the cell. Jail medical personnel assessed his behaviors and instructed that he be moved to a protective cell. A team of six officers responded to the cell, he refused to cooperate, several officers entered the cell, the detainee resisted and began fighting with the officers. The officers placed him in the prone position, he actively resisted and struggled against the officers, and an officer placed his weight on the back of the detainee to secure him in handcuffs. Another officer used the TASER, handcuffs were applied, and the officers placed leg restraints on the detainee's ankles. Within five minutes of the officers entering the cell, the detainee became unresponsive. The detainee subsequently died and the autopsy did not show any significant injury or trauma, although the autopsy indicated the death occurred during restraint. The Eighth Circuit found the district court did not err in granting qualified immunity to the officers as they used objectively reasonable force. The Court noted that the detainee actively resisted at the beginning of the encounter and continued to actively resist the officer's efforts to control him.

In *Lombardo and Gilbert v. Saint Louis City, et al.*⁶² Gilbert was arrested and lodged in a holding cell and attempted to hang himself with his shirt. An officer approached the cell and noticed that Gilbert did not have anything around his neck, grabbed one wrist, placed one handcuff on it, Gilbert began to struggle, other officers responded, placed Gilbert on a concrete bench, and handcuffed the other hand. Gilbert rose up and kicked the officers, lost balance and landed on the bench cutting his head, and an officer radioed for leg restraints. The officers placed Gilbert on the floor, he continued to struggle against the officers, and one officer placed weight on Gilbert's back, another officer placed pressure on Gilbert's legs, while another held his shoulders. The officers applied the leg restraints on his ankles, and the officers called for medical personnel. An officer observed that Gilbert breathing abnormally, rolled him on his side, could not find a pulse, and he stopped breathing. The officers began CPR until emergency medical personnel responded, they relieved the officers, transported him to the hospital, where he pronounced dead. The autopsy revealed that Gilbert had significant heart disease, had a large concentration of methamphetamine in his system, the manner of death was accidental, and the cause of death was arteriosclerotic heart

disease exacerbated by methamphetamine, and forcible restraint. The court granted the officers summary judgment holding that they were responding to a violent detainee who was attempting to harm himself, met active resistance, and continued to resist the officers. The court ruled that the officers use of force was objectively reasonable as the circumstances the officers faced were tense, uncertain, and rapidly evolving and from their perspective, they were justified in using the level of force required to control and restrain Gilbert. Moreover, in *Hanson v. Best, et al.*,⁶³ *Gray v. Cummings*,⁶⁴ *Arrington-Bey v. City of Bedford Heights, et al.*,⁶⁵ and *Pratt v. Harris County TX*⁶⁶ the court granted qualified immunity to the officers who used the prone restraint position, the TASER, and other force measures in accordance with the active resistance of the detainee and in accordance with the objective reasonableness standard, even though the incident resulted in the death of the detainee. Further, the courts found that the officers did not act with deliberate indifference to the medical needs of the detainee.

In *Hooper v. Plummer et al.*⁶⁷ however, the Sixth Circuit denied qualified immunity to detention officers who used the prone restraint position, which resulted in the death of the detainee, which was caused by cardiac arrhythmia and compressional asphyxia. Experiencing a seizure, the detainee collapsed in his cell. Responding officers decided to pull him out of the small cell and placed him on his stomach. Jail medical personnel also responded and the detainee tried to stand up, the officers placed him on his stomach and handcuffed with his hands behind his back. One officer placed his knee on the lower leg of the detainee and one other officer placed his knee on the shoulder blade of the detainee control his thrashing movements. The detainee became unresponsive, the nurse attempted to provide medical treatment but could not while the detainee was prone. The detainee stopped breathing and died. The coroner determined the cause of death was cardiac arrhythmia. The plaintiff's medical expert, however, determined that the detainee died of asphyxia due to the detainee's torso being compressed while he was prone and handcuffed. A §1983 action was filed, claiming the officers used excessive force, acted with deliberate indifference to the detainee's medical needs, and claims against the sheriff for failing to train and supervise the officers, and for unconstitutional policies. The Sixth Circuit affirmed the lower courts' denial of summary judgment and agreed that the officers applied excessive and compressive force upon a restrained detainee's back, shoulders, and legs over the course of twenty-two minutes who was not actively resisting or posed a threat to the officers. Also, the Court concluded that the officers delayed in providing medical care to the detainee in violation of the Eighth Amendment.

Discussion and recommendations

The analysis has shown that the risk of a detainee custodial death in detention facilities across the country is statistically low. Additionally, the death from the use of force during the prone restraint process rarely occurs, given the medical, psychological, substance abuse, and violent behavioral history of detainees, and given the number of detainees that are admitted and released annually. The review of the reputable scientific human subject and epidemiological studies conducted since 1997 showed that being restrained in the prone restraint position and hobbled appear to be no more physiological dysfunctional than any other position, and medically, as well as for officer safety, is an acceptable position for controlling and restraining violent and combative detainees. Additionally, the theory of weight applied to the back of a violent detainee restricts ventilation sufficient to cause asphyxiation has also been refuted by the scientific research demonstrating that ventilation is not comprised. Placing a combative

detainee in the prone restraint position is the preferred and safest position for the officer to control and restrain the detainee. Officers are not taught to place a violent and resisting detainee in the supine position to control and restrain in restraints and it is not safe for the officers. The research has shown that restraint asphyxia by itself is not a sufficient cause of death, and other causes of death and factors should be considered. The scientific research has been applied in several litigated cases, and in many of these cases, the court relied on the research, ruling that the prone restrained position, in and of itself, is not considered deadly force, and it is a reasonable force measure for officers to apply with violent detainees. Based on the review of these selected case decisions, there are several themes which emerge as discussed below.

First, these decisions convey the concern for the daily safety of the officers working in the nations' detention facilities and acknowledge that working with the transient and often violent detainee population is dangerous and measures which can enhance the safety of these officers are paramount to the safe and efficient operation of the facility.

Second, the trends of using force measures in the detention facility with detainees displaying violent behaviors which appeared to be associated with psychological disturbances and/or influenced by illicit drugs emerge as the majority of circumstances in which the prone restraint procedure is frequently used. These incidents commonly occur during the reception and booking process, during a cell extraction or transfer, and in the recreational/dayroom area. Detainees are more likely to display agitation, self-injurious behaviors, bizarre behaviors, refusing orders, assaulting an officer or other detainee, and/or destroying property. The behaviors are commonly consistent with active resistance requiring officers to respond to control and restrain the violent detainee.

Third, litigation trends were described which primarily involved incidents occurring in detention facilities. These trends show that courts are significantly more likely to grant qualified immunity to the responding officers use of force when they can clearly describe: the nature of the encounter circumstances, the location of the confrontation within the detention facility, the type of detainee behaviors and statements made, the type and degree of resistance and threat presented by the detainee, particularly active resistance of the detainee, the perception of the responding officers, the use of verbal commands and attempts to temper the use of force, the facility security issues at risk, the need to use the varying types of force measures applied, including physical control measures, intermediate weapons, and all of the restraints used, ceasing force once the detainee is controlled and restrained, assessing and monitoring the detainee after control and restraint is established, and providing access to medical personnel for assessment and treatment as warranted.

Fourth, prior to *Kingsley*, the lower courts applied varying standards of review when examining a claim of excessive force, in accordance with the Fourth and Fourteenth Amendments. In a majority of the case decisions, the lower courts assessed the excessive force claim in accordance with the objective reasonableness standard established in the *Graham* decision and the Fourth Amendment. In these decisions, the courts were more likely to grant qualified immunity when the officers used the prone restraint position and force measures were objectively reasonable given the circumstances and were not excessively disproportionate to the behaviors and resistance they faced. While the court will consider the facts of the incident from the plaintiff's version, the court will also review the circumstances

the officers faced, and also examine if the circumstances were tense, uncertain, and rapidly evolving. The court will also examine the incident from the officer's perspective and determine whether the officer's force was justified in using the level of force required to control and restrain the detainee. A review of the limited case decisions after the *Kingsley* decision has not significantly changed the force analysis. The objective reasonableness standard, transferred from the *Graham* decision, is applied to excessive force claims stemming from a prone restraint death of a pre-trial detainee, as well as other circumstances of the use of force in the detention facility. Because a pre-trial detainee is not a free citizen and is not a convicted offender, a review of a claim of excessive force is assessed in accordance with the Fourteenth Amendment. Factors the courts consider to determine the reasonableness of the force used include: the officer's perspective, whether the detainee is actively resisting, the relationship between the need to use force and the amount used (proportionately), the severity of the security problem at issue, the threat of reasonably perceived by the officer, whether the officer made any effort to limit the amount of force used, the need to use force was made within seconds under rapidly, tense, and uncertain circumstances, and the totality of the confrontation circumstances. In accordance with the *Kingsley* decision, a major factor in the analysis of an excessive force claim is not only whether the officer's safety is at risk from the detainee but whether the detainee is actively resisting. Based on the court's trends in granting qualified immunity to responding officers in the prone restraint incidents, the officers were successful in demonstrating that the detainee's behaviors were not only dangerous to the detainee, the security of the facility, the safety of the officers, and dangerous to others, but that the detainee actively resisted the officers' efforts of control, thereby justifying the use of force measures, including the use of prone restraint procedures.

Fifth, compare, however, the court's decisions where summary judgment was denied. In those cases, the courts were more likely to determine the officers force was objectively unreasonable when: the officers continued to apply force after detainee stopped resisting and when the detainee was no longer a threat, the officer used force after the need diminished and after the detainee was secured, and when the force was disproportionate to the resistance encountered. The courts acknowledge that there is a fine line between distinguishing cessation of resistance and the need to continue to use force. Hence, officers should pay careful attention to the behaviors of the detainee once he or she is controlled and restrained. Generally, the courts will deny qualified immunity to the officers if the detainee stops resisting in the prone restraint position, is controlled in handcuffs and leg restraints, and the officers continue to apply various use of force measures. Conversely, if the detainee continues to actively resist after being secured in handcuffs, thrashes his body, attempts to stand up, kicks his legs, and poses a risk of safety to himself, others, and the officers, the officers may apply leg restraints, and force measures as appropriate. Consistent with the principles of de-escalation, once the detainee ceases his resistance, the officers should also de-escalate the level of force applied. Officers should also monitor the actions of the detainee and respond appropriately should the detainee re-initiate resistance.

Sixth, the trends of these cases reveal that when responding officers delay and or deny the detainee access to medical care after the detainee is securely controlled and restrained, the courts are likely to deny qualified immunity in accordance with the standard of deliberate indifference. While the standard is a difficult standard for the plaintiff to prove, the court may find in favor of the plaintiff when it can be

determined that the officers were deliberately indifferent to the medical needs of the detainee. Conversely, when officers assess and monitor the detainee's condition after control and restraint, request medical personnel to assess the detainee as warranted, and provide access to emergency medical personnel, the court will be more likely to grant qualified immunity. In these types of the incidents the court's reasoning is that the officer did not act with subjective knowledge of a substantial risk of serious harm and did not act with deliberate indifference toward the detainee's medical needs.

Seventh, the liability trends show that administrative liability can be diminished when the administrator has developed, implemented, and trained facility officers in department policies and procedures. Besides claiming the officers used excessive force, claims that the detention administrator failed to direct officers through department policies and procedures are frequently filed. Commonly the following policies are attacked in a prone restraint death incident: the use of force, use of force equipment, restrain devices, supervision of detainees, responding to the mentally impaired and those under the influence, crisis intervention, and medical care of detainees. Based on the litigated trends described detention administrators should review and revise these policies as warranted. The use of force policy should be developed within the United States Supreme Court's decision in *Kingsley*. The use of force policy should identify and describe all use of force techniques, force equipment, and restraint equipment authorized to use within the facility. The policy should guide officers in assessing detainee resistance and guide officers in the reasonable use of force. The policy should direct officers to assess, monitor, and provide access to medical care after the use of force. The involved officers should be directed to submit a written report and reviewed by a supervisor. In incidents where a detainee sustains a serious injury or results in death, the administrator should convene an investigation.

Eighth, consistent with the United State Supreme Court's decisions in *City of Canton, Ohio v. Harris*⁶⁸ and *Connick v. Thompson*⁶⁹ administrators should provide ongoing training for their officers and supervisors. Training should be regularly provided on the associated policies relevant to prone restraint incidents. Officers and supervisors should also receive training on detention use of force litigation and liability issues. Ongoing training provided in the authorized force techniques, equipment, and restraints will ensure that officers are acting within the guidance of department policies, make appropriate use of force decisions, and are competent in the use of authorized force techniques and equipment. The training should include scenario-based training which allows the officers to practice crisis intervention techniques, the use of physical control techniques, multiple officer control and restraint techniques, and non-deadly force and restraint equipment. The training should match the use of force policy. Administrators are also encouraged to keep officers certified in the administration of First Aid and CPR and officers should receive training on the implications of the ADA during confinement. All training should be documented.

Ninth, periodic training on supervising and responding to detainees who exhibit signs of mental illness and those showing signs of being under the influence of a chemical substance should be provided. These two detainee categories represent a large percentage of the detainee population and represent the majority of detainees involved in prone restraint incidents. Training should be provided which addresses basic symptomologies of these two detainee categories, how to communicate with these detainees, and referring the detainees

to medical and mental health personnel within the detention facility and/or the community. This training should also address the agency's medical response policy and the officer's implementation of the policy.

Conclusion

The death of a detainee from a prone restraint incident described show that such incidents occurrence in detention facilities are rare and cannot be totally eliminated. The trends of the prone restraint litigation in detention show that officers and administrators can place themselves and their agency in the best position to defend such claims by adhering to the current status of the law. Equally, detention officer and officials can ensure they are performing their sworn duties in compliance with the law by using the knowledge gained from the prone restraint science, keeping policies and response strategies current, within court decisions, state law and regulations, and interacting and responding to detainees in accordance with agency policies and training. Following these strategies can assist in demonstrating to the community that agency personnel are executing their duties within accepted and legitimate detention practices.

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None

Conflicts of interest

I affirm and declare that there is no conflict of interest with any aspect associated with this paper.

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