ICE/DRO RESIDENTIAL STANDARD

USE OF PHYSICAL FORCE AND RESTRAINTS

I. **PURPOSE AND SCOPE. After all reasonable efforts to otherwise resolve a situation have failed, staff is authorized to use the minimum physical force necessary for the protection from harm against self, residents, or others; for prevention of escape or serious property damage; or to maintain the security and orderly operation of the facility.**

Staff may use only the degree of force that is necessary to gain control of residents and may use physical restraints to gain control of an apparently dangerous resident, under specified conditions.

This Residential Standard does not specifically address the use of restraints for medical or mental health purposes, which may be authorized only by a qualified medical or mental health provider, after reaching the conclusion that less restrictive measures are not successful, as detailed in the Residential Standard on **Medical Care**.

II. **EXPECTED OUTCOMES.** The expected outcomes of this Standard are as follows:

1. The use of physical force will be restricted to instances of justifiable self-defense, protection of others, protection of property, and prevention of escapes. In these situations, force will be used only as a last resort.
2. Physical force or restraint devices used as punishment will be prohibited.
3. Restraints will not be applied without prior supervisory approval if approval is required.
4. All weapons and related equipment will be stored securely in designated areas to which residents have no access.
5. A written record of routine and emergency distribution of security equipment will be maintained.
6. A written report will be provided to the facility administrator or designee no later than the end of a tour of duty when force was used on any resident, or any resident remains in restraints at the end of that shift.

III. **DIRECTIVES AFFECTED**

None

IV. **REFERENCES**

The First Edition National Residential Standards were written using a variety of methodologies including previous and current practices, review and comment from various subject matter experts, review and comment from various government and non-government organizations, and a review of current state codes in Pennsylvania and Texas. Each standard is written in a manner that affords each resident admission and continuous housing to a family residential facility in a dignified and

respectful manner. There are no specific codes, certifications, or accreditations that deal specifically with unique management requirements of families awaiting the outcome of their immigration proceeding in a non-secure custodial environment.

American Correctional Association Standards for Adult Local Detention Facilities, 4th Edition: 4-ALDF-2B-01, 2B-02, 2B-03, 2B-04, 2B-05, 2B-06, 2B-07, 2B-08, 2C-01, 2C-02, 2C-06, 7B-15, 7B-16.

ICE Interim Use of Force Policy (7/7/2004).

National Enforcement Standard, "Use of Intermediate Force"

V. EXPECTED PRACTICES

1. Overview

- Use of force in Residential facilities is never used as punishment, is minimized by staff attempts to first gain a resident's cooperation, is executed only through approved techniques and devices, and involves only the degree necessary and to reasonably gain control of a resident.
- Various levels of force may be necessary and reasonable, depending on the totality of the circumstances.
- Generally, use of force is either ***immediate*** or ***calculated***, the latter being feasible in most cases and most likely to minimize harm to residents or staff.
- Use of force may involve physical control and placement of a resident in alternate housing and/or the application of various types and degrees of restraint devices.
- Follow-up (medical attention, for example), documentation (including video taping for calculated use of force), reporting, and After-Action Review are required.

2. Principles Governing the Use of Force and Application of Restraints

a. Under no circumstances shall staff use force to punish a resident.

b. Staff shall attempt to gain a resident's willing cooperation before using force.

c. Staff shall use only that amount of force necessary and reasonable to gain control of a resident.

d. Staff may immediately use restraints if warranted to prevent a resident from harming self or others or from causing serious property damage.

e. Facility administrator approval is required for continued use of restraints, if necessary.

f. Staff may apply additional restraints to a resident who continues to resist after staff achieve physical control. If a restrained resident refuses to move or cannot move because of the restraints, staff may lift and carry the resident to the appropriate destination; however, staff may not use the restraints to lift or carry the resident.

g. Staff may not remove restraints until the resident has regained self-control.

h. Staff may not use restraint equipment or devices (for example, handcuffs):

- On a resident's neck or face, or in any manner that restricts blood circulation or obstructs the resident's airways (mouth, nose, neck, esophagus);
- To cause physical pain or extreme discomfort. While some discomfort may be unavoidable, even restraints are applied properly, examples of prohibited applications include, improperly applied restraints, unnecessarily tight restraints, "hog-tying," and fetal restraints (cuffed in front with connecting restraint drawn-up to create the fetal position).
- On a resident child age 14 or under without authorization from a supervisor;
- Restraints shall never be used on a child age 12 or under. Passive restraint techniques should be used to prevent a minor from injuring him/herself or others.
- Check and record the resident's condition at least every 15 minutes to ensure that the restraints are not hampering circulation and to monitor the general welfare of the resident.
- Qualified health personnel ordinarily visit the detainee at least once every two hours until restraints are removed.
- The shift supervisor shall review a resident every hour. If the restraints have had a calming effect, they may be removed and, if appropriate, replaced by a less restrictive device.
- The decision to release the detainee or apply lesser restraints shall shift supervisor shall not be delegated below the shift supervisor's level. The shift supervisor may seek advice from mental or physical health professionals about when to remove the restraints.
- The facility shall immediately notify JFRMU when restraints are required for a resident in a residential facility.

i. Staffs are required to ensure compliance with Crisis Intervention and Defensive Tactics training and the proper application of those techniques. This training is required as basic training before entry on duty and must be provided as a refresher training course annually. Staff shall be trained in these techniques prior to being placed in an on-duty status and shall be recertified annually. Staff shall maintain a one to one watch and monitor all residents placed in restraints until the resident is transferred or the restraints are removed.

j. Hard restraints (for example, steel handcuffs and leg irons) shall be used only after soft restraints prove (or have previously proven) ineffective with a particular resident.

k. Licensed medical personnel may prescribe and administer medication. Medication shall not be used to subdue an uncooperative resident for staff convenience.

l. Staff shall fully document all instances involving physical use of force.

3. **Use of Force Continuum**

The use of force continuum is a five-level model used to illustrate the levels of force staff may need to gain control of a resident, from least to maximum use of force, as follows:

- Mere staff presence without action.
- Verbal interventions and commands
- Soft techniques. Established and accepted techniques from which there is minimal chance of injury.
- Hard techniques. Established and accepted techniques where there is greater possibility of injury.

While staffs are trained and required to use only a level of force that is necessary and reasonable to gain control of a resident, staffs may have to escalate or de-escalate through the use of force continuum.

4. **Training**

General Training

Through ongoing (at least annual) training, all Residential facility staff must be made aware of their responsibilities to control situations involving aggressive residents.

At a minimum, training shall include:

a) The requirements of this Residential Standard;

b) The use of force continuum;

c) Communication techniques;

d) Cultural diversity;

e) Dealing with the mentally ill;

f) Confrontation-avoidance techniques;

g) Approved methods of self-defense;

h) Universal precautions

i) Application of restraints

j) Reporting procedures.

5. **Prohibited Intermediate Force Acts and Techniques**

The following acts and techniques are specifically prohibited:

a. Choke holds, carotid control holds, and other neck restraints;

b. Using a baton to apply choke or "come-along" holds to the neck area;

c. Intentional baton strikes to the head, face, groin, solar plexus, neck, kidneys, or spinal column;

d. Striking a resident for failing to obey an order;

e. Striking a resident when grasping or pushing him/her would likely achieve the desired result;

f. Using force against a resident offering no resistance.

g. Restraining residents to fixed objects.

6. Use of Force in Special Circumstances

Occasionally, after the failure or impracticability of confrontation-avoidance, staff must make a judgment call as to whether to use force. In such cases, for example, involving a child, a pregnant resident, or an aggressive resident with open cuts, sores, or lesions, staff shall, when time and circumstances permit, seek medical advice before deciding the situation is grave enough to warrant the use of physical force.

a. Pregnant Residents

Medical staff shall advise as to precautions required to protect the fetus and pregnant resident, including the manner in which the pregnant resident will be restrained, the advisability of a medical professional's presence when restraints are applied, and the medical necessity of restraining the resident in the facility hospital or a local medical facility.

b. Residents with Wounds or Cuts

All staff shall wear protective gear when restraining aggressive residents with open cuts or wounds. If force is necessary, this gear may include a full-body shield.

Aggressive residents who are violent or exhibit the potential for violence shall be placed in restraints and be removed and kept separate from the general population. Restraints shall remain in place as long as the resident poses a physical threat.

7. Intermediate Force Weapons

In this Residential Standard "Intermediate Force Weapons" refers to weapons often termed "nondeadly force weapons," "non-lethal weapons," or "less-than-lethal weapons."

a. Storage

Intermediate force weapons shall remain stored and out of site of residents during normal operations. Intermediate force weapons and related equipment are permitted only in designated areas:

- Where access is limited to authorized personnel, and
- To which residents have no access.

b. Recordkeeping and Maintenance

Each facility shall maintain a written record of routine and emergency distribution of security equipment and shall specifically designate, and incorporate in one or more post orders, responsibility for staff to inventory related security equipment at least monthly to determine their condition and expiration dates.

c. Use

The facility administrator may authorize the use of intermediate force weapons, if a resident:

- Is armed and/or barricaded; or
- Cannot be approached without danger to self or others; and
- A delay in controlling the situation would seriously endanger the resident or others, or would result in a major disturbance or serious property damage. Serious property damage for the purposes of this standard involves any instance where such damage interrupts the flow of services to residents or adversely affects the daily operations of the facility.

In the use of force continuum, the collapsible steel baton authorized below is an "impact weapon" that is considered:

- A "soft" technique when used during "come alongs" or to apply gradual pressure for compliance, or
- A "hard" technique when used for striking.

As with any use of force, staff using an impact weapon shall choose the appropriate level as required by the totality of circumstances, and its use must be discontinued when adequate control of a resident has been achieved.

d. Authorized Intermediate Force Devices. The following devices are authorized within family residential centers only with the authorization of the ICE facility administrator (for official use only):

- Collapsible steel baton;
- 36" straight, or riot, baton

e. Unauthorized Force Devices. The following devices are not authorized:

- Saps, blackjacks, and sap gloves;
- Mace, CN, tear gas, or other chemical agents,
- Homemade devices or tools; and
- Any other device or tool not issued or approved by the National Firearms and Tactical Training Unit

8. Immediate Use of Force

An "immediate-use-of-force" situation is created when a resident's behavior constitutes a serious and immediate threat to self, staff, another resident, property, or the security and orderly operation of the facility. In that situation, staff may respond without a supervisor's direction or presence.

Upon gaining control of the resident, staff shall seek the assistance of qualified health personnel to immediately:

1. Determine if the resident requires continuing care and, if so, make the necessary arrangements. Continuing care may involve such measures as admission to the facility hospital, restraining a pregnant resident in a way that does not include face-down, four/five-point restraints, etc.
2. Examine the resident and immediately treat any injuries. The medical services provided shall be documented.
3. Examine any involved staff member who reports an injury and, if necessary, provide initial emergency care.

The shift supervisor shall provide a written report to the facility administrator or designee no later than the end of a tour of duty when force was used on any resident, or where any resident remains in restraints at the end of that shift.

9. Calculated Use of Force and/or Application of Restraints

If a resident is in an isolated location (for example, a locked room or area) where there is no immediate threat to the resident or others, staff shall take the time to assess the possibility of resolving the situation without resorting to force.

A calculated use of force shall be authorized in advance by the facility administrator (or designee).

Calculated use of force is feasible and preferred in most cases and is appropriate when the resident is in a room or other area with a securable door. Even if the resident is verbalizing threats or brandishing a weapon, calculated force is often appropriate provided staff see no immediate danger that the resident could cause harm. Calculated use of force affords staff time to strategize and resolve situations in the least confrontational manner possible.

a. Confrontation Avoidance

Before authorizing the calculated use of force, ICE, the ranking Residential official, a designated health professional, and others as appropriate shall assess the situation. Taking into account the resident's history and the circumstances of the immediate situation, they shall devise a plan which will include the appropriateness of using force and the level of force to be used.

The conferring staff may consider, in their assessment, the resident's medical/mental history; recent incident reports involving the resident, if any, and emotional shocks or traumas that may be contributing to the resident's state of mind (for example, a pending criminal prosecution or sentencing, divorce, illness, death, etc.).

Interviewing staff familiar with the resident might yield insight into the resident's current agitation or even pinpoint the immediate cause. Such interviews may also help identify those who have established rapport with the resident, or whose personalities suggest they might be able to reason with the resident.

b. Documentation and Video-taping

While ICE/DRO requires that ***all*** use-of-force incidents be documented and forwarded to ICE/DRO for review, for ***calculated use of force***, it is required that the ***entire incident*** be ***videotaped***. The videotape and accompanying documentation shall be included in the investigation package for the After-Action Review described below.

Written documentation shall include a "Use of Force" form (sample attached) and memorandum reporting staff actions, reactions, and responses during the confrontation-avoidance process.

Calculated use of force incidents shall be videotaped in the following order:

1) Introduction by Team Leader, stating facility name, location, time, date, etc.; describing the incident that led to the calculated use of force; and naming the video-camera operator and other staff present.
2) Faces of all team members briefly appear (helmets removed; heads uncovered), one at a time, identified by name and title.
3) Team Leader offering resident last chance to cooperate before team action, outlining use-of-force procedures, engaging in confrontation- avoidance, and issuing use-of-force order.
4) Entire tape of Use-of-Force Team operation, unedited, until resident is in restraints.
5) Close-ups of resident's body during medical exam, focusing on the presence/absence of injuries; staff injuries, if any, described but not shown.
6) Debriefing, including full discussion/analysis/assessment of incident.

c. Use-of-Force Team Technique

When a resident must be forcibly moved and/or restrained during a calculated use of force, staff shall use the Use-of-Force Team technique to prevent or diminish injury to staff and residents and exposure to communicable disease. The technique usually involves five or more trained staff members clothed in protective gear, including helmet with face shield, jumpsuit, stab-resistant vest, gloves, and forearm protectors. Team members enter the resident's area together, with coordinated responsibility for achieving immediate control of the resident.

1) Staff shall be trained in the Use-of-Force Team technique in sufficient numbers for teams to be quickly convened on all shifts in different locations throughout the facility. To use staff resources most effectively, the facility administrator shall provide Use-of-Force Team technique training for all staff members who could potentially be used in a calculated use-of-force.

2) The Use-of-Force Team technique training shall include the technique and its application, confrontation-avoidance, professionalism, and debriefing.

3) Training shall also address the use of protective clothing and handling of spilled body fluids and blood:

- Use-of-Force Team members and others participating in a calculated use of force shall wear protective gear, with appropriate precautions when entering a cell or area where blood or other body fluids are likely to be present.
- An individual with a skin disease or skin injury shall not participate in a calculated use-of-force action.

4). The shift supervisor or another supervisor on duty:

- Must be on the scene prior to any calculated use of force to direct the operation and continuously monitor staff compliance with policy and procedure;
- Shall not participate except to prevent impending staff injury;
- Shall seek the guidance of qualified health personnel (based on a review of the resident's medical record) to identify physical or mental problems, and, whenever feasible, arrange for a health services professional to be present to observe and immediately treat any injuries;
- Shall exclude from the Use-of-Force Team any staff member involved in the incident precipitating the need for force;
- May expand the Use-of-Force Team to include staff with specific skills.

5). When restraints are necessary, the team shall choose ambulatory or progressive models.

6). The supervisor shall provide a written report to the facility administrator or designee, no later than the end of a tour of duty, when force was used on any resident, or any resident remains in restraints at the end of that shift.

10. Evidence Protection and Sanitation

The supervisor shall inspect areas of blood or other body-fluid spillage after a use-of-force incident, and unless he or she determines that the spillage must be preserved as evidence, staff or properly trained residents' shall immediately sanitize those areas, based on medical department guidance on appropriate cleaning solutions and their use. The Residential Standard on **Environmental Health and Safety** also provides detailed guidance for cleaning areas with blood and other body fluid spills.

Standard sanitation procedures shall be followed in areas with blood or other body-fluid spillage. Wearing protective gloves, staff and/or residents shall immediately apply disinfectant to and sanitize such surfaces as walls and floors, furniture, etc. Articles of clothing and use-of-force equipment contaminated with body fluids shall likewise be disinfected or destroyed, as needed and appropriate.

11. Maintaining Video Recording Equipment and Videotapes

If videotaping equipment is kept in a designated area, staff shall store and maintain it under the same conditions as Class "A" tools. If a designated area lacks appropriate secure space, the equipment must be kept in a secure location elsewhere in the facility.

Since video recording equipment must often be quickly available, each facility administrator shall designate, and incorporate in one or more post orders, responsibility for:

- Maintaining cameras and other video equipment;
- Regularly scheduled and documented testing to ensure all parts, including batteries, are in working order; and
- Keeping back-up supplies on hand (batteries, tapes, lens-cleaners, etc.).

Each videotape shall be catalogued and preserved no less than 5 years after its last documented use. In the event of litigation, the facility shall retain the tape until its destruction is authorized by ICE.

The tapes may be catalogued electronically or on 3" x 5" index cards, provided the data can be searched by date and resident name. A log shall document videotape usage.

Use-of-force tapes shall be available for supervisory, Field Office and Headquarters incident reviews and may also be used for training.

Release of use-of-force videotapes to the news media may occur only if authorized by Headquarters, in accordance with ICE/DRO procedures and rules of accountability.

12. Approved Restraint Equipment

Deviations from the following list of restraint equipment are prohibited:

- Handcuffs: Stainless steel, 10 oz.;
- Leg Irons: Stainless steel, meet National Institute of Justice standard;
- Martin chain
- Waist or Belly Chain: Case-hardened chains with a minimum breaking strength of approximately 800 pounds;
- Handcuff Cover: Highly effective cases for the security of handcuffs used on high security residents;
- Soft Restraints: Nylon/leather type with soft arm and leg cuffs containing soft belts with key locks;
- Plastic Cuffs: Disposable;

- Any other ICE/DRO-approved restraint device.

13. Ambulatory and Progressive Restraints

Whenever possible, staff shall apply **ambulatory restraints**, which are soft and hard equipment that provides freedom of movement sufficient for eating, drinking, and other basic needs without staff assistance or intervention;

If ambulatory restraints are insufficient to protect and control a resident, staff may apply **progressive restraints**, which are more secure or restrictive. The facility administrator shall decide on the appropriate restraint method.

Once a resident has been placed on ambulatory restraints, the medical staff is required to conduct a physical check of the resident once every two hours to assess health status. Facility staff is required to conduct a physical check of the resident once every two hours to assess if the restraints have had a calming effect. If the positive behavioral change has been achieved, a decision to remove the resident or place them in less restrictive restraints shall be made by the facility administrator in consultation with ICE/DRO. If a calming effect has not been achieved, the shift supervisor shall document the reason for continuance of the ambulatory restraints.

The supervisor shall provide a written report to the facility administrator, no later than the end of the tour of duty, when any resident remains in restraints at the end that shift.

14. Four/five-point Restraints

Four/five-point restraints shall not be used in a family residential center

15. Documentation of Use of Force and Application of Restraints

Staff shall prepare detailed documentation of all incidents involving the use of force. Staff shall likewise document the use of restraints on a resident who becomes violent or displays signs of imminent violence. A copy of the report shall be placed in the resident's Residential file.

a. Report of Incident

All facilities shall have an ***ICE/DRO-approved*** form to document all uses of force.

Staff shall prepare a "Use of Force" form (sample attached) for each incident involving use of intermediate force weapons, application of progressive restraints (regardless of level of resident cooperation), etc. The report identifies the resident(s), staff, and others involved, and describes the incident. If intermediate force weapons are used, for example, collapsible steel baton or 36-inch straight (riot) baton, the location of strikes must be reported on the Use of Force form. Each staff member shall complete a memorandum for the record, to be attached to the original Use of Force form. The report, accompanied by the medical report(s) must be submitted to the facility administrator by the end of the shift during which the incident occurred.

Within two working days, copies of the report shall be placed in the resident's A-File and sent to ICE/DRO.

b. Videotapes of Use-of-Force Incidents

Staff shall immediately obtain and record with a video camera any use-of-force incident, unless such a delay in bringing the situation under control would constitute a serious hazard to the resident, staff, or others, or would result in a major disturbance or serious property damage.

The facility administrator shall review the videotape within four working days of the incident and shall immediately send ICE/DRO a copy. When an immediate threat to the safety of the resident, other persons, or property, makes a delayed response impracticable, staff shall activate a video camera and start recording the incident as quickly as possible. After regaining control of the situation, staff shall follow the procedures applicable to calculated use-of-force incidents.

c. Recordkeeping

All facilities shall have a designated individual to maintain all uses of force documentation.

16. After-Action Review of Use of Force and Application of Restraints

a. Written Procedures Required

All facilities shall have ICE/DRO-approved written procedures for After-Action Review of use-of-force incidents (immediate or calculated) and applications of restraints. The primary purpose of an After-Action Review is to assess the reasonableness of the actions taken and whether the force used was proportional to the apparent threat.

b. Composition of an After-Action Review Team

The facility administrator, the assistant facility administrator, ICE and the Health Services Administrator shall conduct the After-Action Review. This four-member After-Action Review Team shall convene on the workday after the incident. The After-Action Review Team shall gather relevant information, determine whether policy was followed, and complete an After-Action Report to record the nature of their review and findings. The After-Action Report is due within two working days of the resident's removal from restraints.

c. Review of Video Tape

The After-Action Review Team shall also review the videotape for compliance with all provisions of this standard, specifically including, among other things:

Strict compliance with the Use-of-Force Team Technique, professionalism of shift supervisor, every team member wearing prescribed protective gear, and action taken by the team.

Absence of towels, tape, surgical masks, hosiery, and other unauthorized items, equipment or devices;

Team members applying only as much force as was reasonably necessary to subdue the resident. This includes responding appropriately to a subdued or cooperative resident, for example, one who discontinues his/her violent behavior,

Shift supervisor clearly in charge of team and situation. This includes intervening at first sign of one or more team members applying more force than necessary

Resident receiving and rejecting opportunity to submit to restraints voluntarily before team enters the cell/area. If he or she submits, team action should not be necessary;

Team members applying restraints exert no more pressure than necessary to the resident's thorax (chest and back), throat, head and extremities;

Amount of time needed to restrain the resident. If team requires more than five minutes, for example, with a resident who is not resisting, this could indicate training problems/ inadequacies;

Protective gear worn by team members inside cell/area, until end of operation;

Continuous photographic coverage from the time the camera starts recording until the incident is over. The review team shall investigate any breaks or sequences apparently missing from the videotape;

A medical professional promptly examining the resident, with the findings reported on tape;

Team member(s) addressing remarks that are derogatory, demeaning, taunting, or otherwise inappropriate or inflammatory, to any resident or person(s) outside the room or area.

The after action report shall include orienting all members of the team as to what occurred, determining whether a pattern of behavior of the resident or pattern of response in the staff could be identified, identifying alternatives for the resident, and negotiating with the resident as to future conduct.

A determination regarding transfer or return of the resident to housing shall be made and a recommendation forwarded to facility administrator and ICE.

If the incident review reveals a violation of ICE/DRO policy or procedures, the After-Action Review Team shall determine whether the situation called for improvised action and, if so, whether the action taken was reasonable and appropriate.

The After-Action Review Team shall complete and submit its After-Action Review Report to the facility administrator within two working days of the resident's release from restraints. The facility administrator shall review and sign the report, acknowledging its finding that the use of force was appropriate or inappropriate. The facility administrator shall agree or disagree with the review team's recommendations. When the facility administrator does not concur, he or she shall list any reasons for non-concurrence and shall make a determination as to cause and remedies,

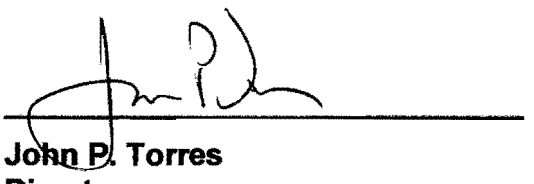
d. Report of Findings to ICE/DRO

Within two working days of the After-Action Review Team's determination, the facility administrator shall report the finding of appropriate or inappropriate use of force the outcome of the After-Action Review, and whether in the Facility Administrator's opinion the use of force was appropriate or inappropriate. The report shall be made via memorandum, to ICE/DRO with appropriate attachments..

d. Further Investigation

The review team shall make recommendations as to whether the incident requires further investigation and whether the incident should be referred to the Office of Professional Responsibility, the Department of Homeland Security Office of the Inspector General, or the Federal Bureau of Investigation.

Standard Approved:



DEC 21 2007

John P. Torres
Director
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Date