

Version 2 - July 2007

Extended operational Deployment of Taser for Specially Trained Units

(excluding firearms incidents)



Policy

Extended operational deployment of Taser

Policy

1 PURPOSE

- 1.1 An initial Taser trial commenced on the 21st April 2003 and lasted for a period of 12 months. This examined the use of Taser as a less lethal option alongside conventional firearms (within a firearms authority). In September 2004, following independent evaluation, the Home Secretary authorised Taser for all Forces as a less lethal option for police operations involving the deployment of AFOs. Having examined all 'uses' to date the Association of Chief Police Officers (ACPO) have concluded that an extension is appropriate in other conflict management situations where the criteria to authorise the issue of firearms are not met.
- 1.2 A submission was presented to the Home Office seeking an extension to the operational deployment of Taser outside of the firearms criteria. Having now considered this submission the Home Secretary is supportive of an extension and a further small trial involving specially trained officers.
- 1.3 This document sets out the policy for the trial of the extended operational deployment of Taser by specially trained officers in non-firearms situations involving violence or threats of violence of such severity that they would need to use force to protect the public, themselves or the subjects.

2 BACKGROUND

- 2.1 In light of the Human Rights' Act the need for a range of 'less lethal' options, and personal safety tactical options in conflict management by police, has become an imperative for the service. Police are required to justify any use of force, showing that it was proportionate and legal, and that there was, at the time, an absolute necessity, particularly where potentially lethal force is used. Available less lethal technologies work in different ways and each may offer unique advantages in specific circumstances. The Association of Chief Police Officers (ACPO) believe that extending the range of options available is likely to provide the most appropriate response to any given situation. This will include the Conducted Energy Devices, HOSDB currently only authorise the Taser.
- 2.2 The usage thus far has demonstrated that where Taser has been used, it has contributed to the effective resolution of the incident. Taser is not a replacement for existing personal safety tactical options, but is an option that should be considered alongside other personal safety tactical options, such as negotiation, batons, incapacitant sprays and dogs. These do not constitute a hierarchy of lawful force and should be viewed as a range of approved options

from which the most proportionate and appropriate should be selected, according to circumstances, in order to meet the obligations set out above and below.

- 2.3 The Conflict Management Model, contained within the ACPO Personal Safety Manual of Guidance sets out the process by which a measured and appropriate response can be made to any situation involving conflict. The police use of force is governed by:
- Common Law
 - Section 3 Criminal Law Act 1967
 - Section 117 Police and Criminal Evidence Act 1984
 - The Human Rights Act 1998
- 2.4 Nothing in this policy overrides the fundamental duty of police officers to protect life in accordance with the law and the European Convention on Human Rights.
- 2.5 Taser technology has been subjected to rigorous assessment and testing by the Home Office Scientific Development Branch (HOSDB) to determine how well it meets the operational requirement.
- 2.6 In addition, the Defence Science and Technology Laboratory (DSTL) has undertaken a thorough programme of medical assessment.
- 2.7 The results of these assessments have been considered by an independent body, the Defence Scientific Advisory Council's sub-committee on the Medical Implications of 'Less Lethal' technologies (DOMILL), who have issued medical statements in relation to Taser. (see appendix B)

3 SCOPE

- 3.1 DOMILL statements together with the findings from the operational usage thus far support this policy document and the proposed wider deployment.
- 3.2 ACPO considers that Taser may be issued alongside other existing personal safety tactical options. If justifiable and necessary it could be selected and used by trained officers facing violence or threats of violence of such severity that they will need to use force to protect the public, themselves and/or the subject(s).

4 OPERATIONAL AND TRAINING ISSUES

- 4.1 The intention is to provide Chief Officers, operational commanders and officers with written guidance on the use of the equipment. The issue, deployment and use of Taser will conform to the well-established guidance already laid down in the ACPO Manual of Guidance on Police Use of Firearms and the ACPO Personal Safety Manual of Guidance.

4.2 The following principles will apply in respect to authority to deploy Taser

- Tasers are to be deployed with Specially Trained Officers, where the authorising officer has reason to suppose that they, in the course of their duty, may have to protect the public, themselves and /or the subject(s) at incidents of violence or threats of violence of such severity that they will need to use force.
- Taser will be readily available.
- Once deployment as a Taser option has been authorised, to conflict management situations, usual supervision will apply.
- Due to the diverse nature of policing operations it is not possible to provide a definitive list of circumstances where the use of Taser would be appropriate. Operational guidance has been written to inform and support decision making in relation to an operational trial stipulating training, deployment and use.

4.3 Officers will be trained in line with the above principles.

4.4 Detailed instructions on the characteristics, operation and use of the Taser will be covered in the training and documentation provided to officers to be accredited in its use.

4.5 No individual will be voluntarily subjected to the effects of Taser under any circumstances.

4.6 Protection is provided to officers who use the Taser and those upon whom it is used, by the data recorded by the device on each occasion that it is discharged.

5 POST INCIDENT PROCEDURES

5.1 In any situations where the Taser is discharged, appropriate post incident procedures will be implemented depending on the nature of the injury or harm occasioned.

5.2 The term 'use of the Taser' will include any of the following actions carried out in an operational setting:

1. Drawing of a device in circumstances where any person perceives the action as a use of force or threat of a use of force, whether or not this is accompanied by a verbal warning, sparking of the device or placing of the laser sight red dot onto a subject.
2. Firing of a device so that the barbs are discharged at a subject.
3. Application and discharge of a device in 'drive stun mode' to a subject.

5.3 Taser discharges are only required to be referred to the Independent Police Complaints Commission (IPCC) if the discharge:

- resulted in death or serious injury;
- caused danger to the public, or
- revealed failings in command.

5.4 This does not preclude forces referring discharges in other circumstances if they think it appropriate. This might include, for example, where Tasers are used outside current policy guidelines.

5.5 In the event of an unintentional discharge where there has been no danger to the public, this will be subject to an internal investigation.

5.6 Below is the minimum standard **where possible** of post incident evidence recovery. Forces should consider the availability of evidence collection equipment including cameras and appropriate packaging.

Cartridge	Including wires and probes to show complete and range used at. Not to be spooled.
AFIDs	Two or three to confirm serial number. These are spread randomly and will not show trajectory.
Photographs	Incident detail to show; scene, weapons involved / available to suspect, AFID / officer location, suspect locations, injuries to police / suspect, barbs location. Intention to tell as much of the incident in photographic detail as possible.
FME Report	Persons Tasered should be examined by FME
Taser Evaluation Form	Required for national records, forward to ACPO
Use of Force report	Required for national records.
Data-port Download	Print out of Taser use record

6 EVALUATION

6.1 The operational use of Taser will be monitored by the ACPO, HOSDB, DSTL and DOMILL.

6.2 Operational usage will be reviewed at regular intervals to ensure that emerging issues are properly reflected in training and operational guidance. Representatives of HOSDB, DSTL and DOMILL will be invited to contribute to the process.

- 6.3 Taser Evaluation Forms will be completed on every occasion where Taser is used in a policing operation. (See Appendix H)
- 6.4 Forces should appoint a Taser Liaison Officer as a single point of contact in each force who should receive all Taser Deployment forms prior to them being submitted centrally for evaluation. This individual will then be the conduit between the force and the representative from the Conflict Management Portfolio in terms of clarifying any information on the form.

REVIEW

- 7.1 This policy will be subject to regular review.

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Operational Guidance

Extension to operational deployment of Taser

Notes for Guidance on Police Use

Index	Page
Preface	9-10
Introduction	11
Description of Equipment	11
Modes of Operation	11
Effects of the Taser	12
Issue/Possession	12
Possession outside Force Area	13
Specific Risk Factors	13-15
Training	15
Use	15-16
Oral and Visual warnings	16
Aftercare	16-18
Post Incident Procedures	18
Battery Maintenance	18
Dataport Auditing	18
Storage and Health and Safety	18-19
Appendix 'A'... Cross Border Protocols	20
Appendix 'B'... Independent Medical Statement	21
Appendix 'C'... Information sheet to subject/GP/Hospitals	22-28
Appendix 'D'...Taser Battery Usage Form	29
Appendix 'E'...Taser Battery Recharging Form	30
Appendix 'F'...Generic Risk Assessment	31-33
Appendix 'G'...Health and Safety Legislation	34
Appendix 'H'...Taser Deployment form	35
Appendix 'I' ... Selection and refresher training	36

Preface

- 1.1 Managing conflict and responding to violence are core police functions. Police response is underpinned by Human Rights and in particular the obligation under Article 2 of the European Convention on Human Rights, to uphold the right to life.
- 1.2 The guidance is intended to inform an extended pilot designed to evaluate the use of the Taser in a wider operational environment. The trial of Taser will be to specially trained officers in non-firearms situations when officers would be facing violence or threats of violence of such severity that they would need to use force to protect the public, themselves and or the subject(s). The extension of Taser will be subject to a 12 month evaluation report by Conflict Management Portfolio / HOSDB.
- 1.3 The Secretary of State is supportive of an extension of the use of Taser.
- 1.4 The use of the Taser will be informed by reference to the ACPO Conflict Management Model, and is intended to provide Taser trained officers with an additional means of dealing with violence or threats of violence of such severity that it is likely that they will need to use force in order to protect the public, themselves and/or the subject(s). The availability or deployment of the Taser should not be considered as a replacement for conventional firearms should the relevant criteria for the issue of firearms be met:

Authorised Firearms Officers (AFOs) are, in accordance with the ACPO Manual of Guidance on Police Use of Firearms, issued with firearms – where the authorising officer has reason to suppose that they, in the course of their duty, may have to protect themselves or others from a person who is

- *in possession of a firearm, or*
 - *has immediate access to a firearm, or*
 - *is otherwise so dangerous that the officer's use of a firearm may be necessary*
 - *for the humane destruction of animals which are dangerous or suffering unnecessarily*
- 1.5 The police use of force is governed by:
 - Common Law
 - Section 3 Criminal Law Act 1967
 - Section 117 Police and Criminal Evidence Act 1984
 - The Human Rights Act 1998

- 1.6 Article 2 of the UN Basic Principles on the use of Force and Firearms states that:
'Governments and law enforcement agencies should develop a range of means as broad as possible and equip law enforcement officials with various types of weapons and ammunition that would allow for a differentiated use of force and firearms.'
- 1.7 The extension of the use of Taser is intended to provide officers, in participating areas, with a differentiated use of force. The Taser will be deployed alongside other personal safety tactical options already available to officers in participating forces.
- 1.8 This guidance will be subject to regular review.

1 Introduction

- 1.1 The purpose of this guidance is to inform and support decision-making relating to selection, training, deployment and use of the Taser.
- 1.2 The intention is to provide Chief Officers, operational commanders and Taser trained officers with written guidance on the use of the equipment in circumstances outside of the firearms criteria.
- 1.3 Detailed instruction on the characteristics, operation and use of the Taser will be covered in the training and documentation provided to officers to be accredited in its use.

2 Description of equipment

- 2.1 The Taser is a single shot weapon designed to temporarily incapacitate a subject through the use of an electrical current, which temporarily interferes with the body's neuromuscular system.
- 2.2 The Taser is laser-sighted and uses cartridges attached to the end of the cartridge bay. The cartridges project a pair of barbs or darts attached to insulated wires. The maximum range of the device is currently 21 feet (6.4 metres); this being the length of the wires that carry the current and attach the barbs to the weapon. It may also be used in a direct contact stun mode.
- 2.3 The device delivers a sequence of high voltage pulses of very short duration through the wires.
- 2.4 The normal reaction of a person exposed to the discharge of the Taser is the loss of some voluntary muscle control resulting in the subject falling to the ground or 'freezing' on the spot. The device relies on physiological effects other than pain alone to achieve its objective, although pain is the main factor when it is used in 'drive stun' mode.

3 Modes of operation

- 3.1 The Taser may be operated with or without the cartridge designed to fire the wires and contact barbs. The electrical flow can therefore be delivered to a subject either by:
 - means of two barbs, attached to the weapon by fine insulated wires, fired into the subject or their clothing; or
 - direct contact with the device in 'drive stun' mode. This method of delivery can be achieved with either no cartridge fitted or when a discharged cartridge is still attached.
- 3.2 To be effective, the Taser power source must have sufficient charge, the wires connecting the barbs to the Taser require to remain intact, both darts (or in

'drive stun mode' both electrodes) require to make contact with the subjects body or clothing.

4 Effects of the Taser

- 4.1 In either mode the Taser delivers its electrical charge in a five-second cycle (which can be broken or repeated), but once the cycle ends or is broken, the direct incapacitation effect ceases.
- 4.2 In most cases this application will be sufficient to render a subject incapable of commencing or continuing an attack and is likely to result in the subject collapsing to the ground. The effect is not intended nor is it likely to render the subject into a state of unconsciousness.
- 4.3 Provided both barbs attach correctly with sufficient spread, the effects are likely to be instantaneous. It should, however, be remembered that no incapacitating device, is universally effective and there may be individuals on whom the Taser may not be effective at all or only partially so.
- 4.4 The direct incapacitating effect is only likely to last for as long as the electrical charge is being delivered. The subject may recover immediately afterwards and could continue with their previous behaviour. It is therefore important that an incapacitated subject is approached and restrained quickly and effectively.
- 4.5 Whilst the five second cycle can be repeated if the incapacitation effect does not appear to take effect, officers should consider other options as there may be technical or physiological reasons why the device is not working as expected on a particular individual.

5 Issue/Possession

- 5.1 For the purpose of this extended pilot the Taser will only be issued to selected (see appendix I), specially trained officers who have successfully completed approved ACPO sponsored training in the use of the device.
- 5.2 Conducted Energy devices are classified as 'prohibited weapons' by virtue of Section 5 Firearms Act 1968. Police officers whilst acting in their capacity as such, are exempt from the requirements of the legislation and do not need any additional legal authority to possess the Taser.
- 5.3 The Taser should not be regarded as a replacement for other issued "work equipment" or for conventional firearms but rather one of a number of personal safety tactical options. An officer may also need to resort to another option if the device does not have the effect intended.
- 5.4 In circumstances where Taser officers have been deployed to an incident, the decision to deploy Taser will include the understanding that it accompanies the full range of conflict management options available to those officers.

- 5.5 It would be inappropriate for commanders or supervisory officers to attempt to restrict the deployment of a Taser trained officer to a particular use of force option.
- 5.6 The limited range and single shot capability of the Taser are also constraining factors.
- 5.7 The Taser normally causes immediate incapacitation and its effect may also cause muscles to contract. This may result in immediate and involuntary clenching of the fingers and/or the arms rising uncontrollably. This potential reaction requires to be factored into any decision to utilise the Taser against a subject holding a weapon. If it is believed to be a firearm, the application of the Taser may cause the subject to unintentionally and indiscriminately discharge the firearm. Additionally, it has been shown that it is possible, in certain circumstances, for some individuals to maintain enough control to attack with a weapon whilst under the effects of Taser.
- 5.8 However, if the weapon is merely close to hand the Taser may be useful in preventing the subject gaining access to the weapon.

6 Possession outside Force area

- 6.1 Taser trained officers may on occasions be deployed outside of their immediate Force area. Chief Officers in pilot Forces will agree a protocol with neighbouring Forces (Appendix A) outlining the circumstances in which officers equipped with the Taser can utilise the device should they be required to respond in a neighbouring Force area. Individual Chief Officers will remain vicariously liable in civil law for their own officers' actions. Guidance for the use of the Taser, whether within or outside the Force area, is set out below.

7 Specific Risk factors

- 7.1 The most recent DOMILL statement reference DSTL/BSC/27/01/07 dated 30 May 2007 identifies that children and adults of smaller stature as being at potentially greater risk from the cardiac effects of Taser currents than normal adults of average or large stature. DOMILL recommends that STUs should be particularly vigilant for any Taser-induced adverse responses in this subset of the population.
- 7.2 Occasions will arise where it is necessary to use the Taser on a person who is exhibiting violent behaviour and who is also suffering from a mental disorder or illness. Where it is possible to discuss options with mental health professionals this should be considered.
- 7.3 In pre-planned operations such discussions could form part of any briefing for the event. Consultation with friends, relatives etc., who are likely to know the person well, may also assist in deciding on the most appropriate use of force response. Consultation with Health Authorities and Social Services in this respect will form part of the implementation plan. (See independent medical

statement Appendix 'B'). The final decision to use the Taser in these circumstances will rest with the officer concerned.

- 7.4 Similarly where it becomes apparent that the subject has an existing medical condition or is under the influence of drugs, assessment of these additional risk factors should be made in determining the appropriate option.
- 7.5 Research by HOSDB has demonstrated that there is a risk of flammability if someone has already been sprayed with an incapacitant containing a flammable solvent. Clearly, there is also a risk of flammability where the subjects' clothing is doused with other flammable liquids. These might include, but are not limited to, lighter fuel, petrol and strong alcoholic spirits.
- 7.6 This heightened risk must be factored in when assessing the 'appropriateness' and 'necessity' of using a Taser. It is however recognised that there are circumstances where the only alternative may be a more injurious level of force, or where activation of the Taser, irrespective of the additional risk, is absolutely necessary to protect life.
- 7.7 Further risk has been identified from use of Taser in proximity to a number of explosive formulations, which are sensitive to electrical discharge. One such group is the 'organic peroxide explosives' such as HMTD and TATP. Items that produce an electrical discharge (such as Taser) will set off peroxide explosives and other sensitive explosives. Other explosive materials may also be sensitive to electrical discharge, depending on how the material is packaged, its age, storage conditions and other factors. The heightened risk, in relation to subjects who may be holding or in close proximity to an improvised explosive device, must also be factored in when assessing the 'appropriateness' and 'necessity' of using a Taser. The potential threat of the subject still being able to initiate the improvised explosive device must also be taken into account.
- 7.8 The Taser should not be utilised in an environment where, due to the presence of a flammable substance in the atmosphere or escaping gas, its use is likely to result in an even more hazardous situation.
- 7.9 The normal reaction of a person exposed to the discharge of a Taser is the loss of some voluntary muscle control resulting in the subject falling to the ground or 'freezing' on the spot. For this reason there is clearly a possibility of some secondary injury to the Tasered subject, caused by falling and striking a hard surface. Particular attention should therefore be paid to the immediate environment and to assessing any additional risk factors. This issue will be particularly relevant where the subject is located at some height above the ground where there is increased risk from a fall.
- 7.10 Repeated, prolonged and/or continuous exposure to the Taser electrical discharge may cause strong muscle contractions that may impair breathing and respiration, particularly when the probes are placed across the chest or diaphragm. Users should avoid prolonged, extended, uninterrupted discharges

or extensive multiple discharges whenever practicable in order to minimise the potential for over-exertion of the subject or potential impairment of full ability to breathe over a prolonged time period.

- 7.11 There is a specific risk of injury to the eye through penetration of a barb. Barb penetration in the neck or head may also increase the level of injury. For this reason the Taser should not be aimed so as to strike the head or neck of a subject unless this is unavoidable. The laser sight should not intentionally be aimed at the eyes of the subject.

8 Training

- 8.1 The aims and objectives of training in the use of the Taser are contained in the Taser training Module.
- 8.2 Tactical training in the use of the Taser should emphasise precautions in relation to the specific risk factors contained in this guidance.
- 8.3 Taser trained officers must be made aware of the dangers associated with the conditions known as Positional Asphyxia and Acute Behavioural Disorder.
- 8.4 It is important that officers have an appreciation of the physical and psychological effects of conducted energy devices.

9 Use

- 9.1 Use of the Taser is one of a number of tactical options available to an officer who is faced with violence or the threat of violence. Its purpose is to temporarily incapacitate an individual in order to control and neutralise the threat that they pose. It is not to be used to inflict severe pain or suffering on another in the performance or purported performance of official duties (The Criminal Justice Act 1988, s.134)
- 9.2 The duration of the initial discharge and any subsequent discharge must be proportionate, lawful, appropriate, necessary and non-discriminate, in all the circumstances. The decision to use the Taser is an individual one for which the officer will be accountable. The Conflict Management Model should assist officers in making such judgements.
- 9.3 Officers will carry out appropriate function checks in accordance with their training whenever the weapon is issued.
- 9.4 When the Taser is discharged at a subject, a separation of the two barbs greater than 8" (200 mm) is desirable in order to provide maximum incapacitation. This separation is achieved at a range of 5 feet (1.5 metres). The separation of the barbs increases with range. It is also important that the

barbs penetrate the subjects' skin or at least attach onto their clothing, otherwise the circuit cannot be completed.

- 9.5 The Taser is sighted so that the top barb will strike in the area of the projected laser sight. It is acknowledged that there will be diminished accuracy and a fall off in trajectory at ranges in excess of 15 feet (4.6 metres). Ordinarily the Taser should be aimed to strike the body mass below the neck. Because of the specific risks previously highlighted (para. 7.11) the Taser should not be aimed so as to strike the head or neck of a subject unless this is wholly unavoidable. The laser sight should not intentionally be aimed at the eyes of the subject.
- 9.6 In stun mode the Taser should be pressed directly to the subjects body. Unless absolutely necessary in order to protect life the Taser should not, due to increased level of injury potential, be applied directly to the subjects' neck or head.
- 9.7 The risk of an officer receiving an electric shock whilst handling a subject who is being Tasered is low provided that the officer does not place any part of their body directly between the points of contact of the barbs on the subjects' body.
- 9.8 The Taser deployment form (See appendix H) is to be completed for every incident where Taser is used.

10 **Oral and Visual warnings**

- 10.1 Where circumstances permit, officers should give a clear warning of their intent to use the Taser, giving sufficient time for the warnings to be observed, unless to do so would unduly place any person at risk, or would be clearly inappropriate or pointless in the circumstances of the incident.
- 10.2 It may in certain circumstances be appropriate to provide a visual display of the sparking effect of the unloaded Taser in order to induce compliance, thus avoiding the need to actually discharge the Taser at the subject.
- 10.3 The visual effect of the laser sight being directed at an individual may also have a deterrent effect. Officers should be aware that the pointing of a Taser at an individual represents a use of force and may in certain circumstances constitute an assault.
- 10.4 Police officers shall give the clear verbal warning 'Taser, Taser' indicating to all persons in the vicinity that Taser is being discharged.

11 **Aftercare**

- 11.1 Recovery from the direct effects of the Taser should be almost instantaneous, once the current has been turned off. After application of the Taser and once

the subject has been properly restrained it is important that the officer provides verbal reassurance as to the temporary effects of the Taser and instructs the subject to breathe normally. This will aid recovery and mitigate against hyperventilation.

- 11.2 The barbs are designed to penetrate either the clothing or the skin. Injuries caused by Taser barbs penetrating the skin are normally minor.
- 11.3 Unless there is an operational necessity no attempt should be made by officers to remove the barbs which have penetrated the skin. This should only be done by a medical professional either at the scene, at a hospital or in the custody suite. This is principally because of the requirement for infection control, the potential for additional trauma to the skin and superficial tissues of the subject, and risk of self-injury. Medical staff only should remove needles/barbs in particularly vulnerable areas such as the eyes. In the event of there being an operational necessity, only officers trained in barb removal and the risks should carry out the procedure.
- 11.4 However, officers also have a duty of care in relation to the well being of individuals under their control. Where it is evident that the barbs are attached to clothing (with no penetration of the skin) they may be removed by gently pulling on the barbs. Care should be taken not to unnecessarily further damage the clothing.
- 11.5 Once the barbs are removed, they must be secured as evidence and any injury or damage noted. Barbs removed from the body should be considered as biohazards. It is important that suitable evidential containers are readily available. Once removed the barbs must be examined to ensure that they are complete.
- 11.6 Where officers are informed or come to believe that a person to whom the Taser had been applied has a cardiac pacemaker or other implanted device, immediate referral should be made to a hospital. Similarly, if the subject is found to have any other pre-existing medical condition that might lead to increased medical risk immediate referral to a hospital should be considered.
- 11.7 All arrested persons, who have been subjected to the discharge of a Taser, must be examined by a Force Medical Examiner as soon as practicable.
- 11.8 Close monitoring of a subject throughout the period following application of the Taser is of utmost importance. If the person is detained in a cell they should be subject to the same cell supervision provided for persons who have consumed alcohol or drugs. If there are any signs of adverse or unusual reactions then medical attention should be provided immediately and if necessary this must be given precedence over conveying the subject to the police station.
- 11.9 Experience from the use of Tasers in other countries, which is supported by medical assessment in the UK, has shown that the persons most likely to be at greatest risk from any harmful effects of the Taser device are those also

suffering from the effects of drugs or who have been struggling violently. There are cases where such persons exposed to the effects of Taser have died some time after being exposed although the cause is unlikely to have been Taser itself. For this reason, such persons should be very closely monitored following exposure to the effects of the Taser. In addition, and as highlighted in other guidance, if there is any suspicion at all that the violent behaviour of any subject is being caused by acute behavioural disorder; they should be treated as a medical emergency and conveyed directly to hospital.

- 11.10 At the earliest opportunity following arrival at the custody suite any person who has been subjected to a Taser discharge should be given an information leaflet describing the Taser, its mode of operation and effects. (See Appendix 'C'). This should be fully explained and recorded on the custody record.

12 Post Incident Procedures

See Policy.

13 Battery Maintenance

- 13.1 M26 - Proper maintenance of the Taser batteries is vitally important to the weapons operation. Guidance on this issue is included in maintenance forms for the device and batteries (see Appendices 'D' & 'E').
- 13.2 X26 – Function checks should include checking of battery percentage remaining (Digital Power magazine - DPM) and replacement of batteries when percentage reaches a minimum of 10% on the display for operational Tasers.

14 Dataport Auditing

- 14.1 An internal data logging system within the Taser records the details the previous 1500 activations on the X26 (585 on the M26). This shows the exact time and date that the current was discharged. On the X26 the length of the discharge, temperature and battery condition is also shown. Details of activations can be downloaded via the dataport on to computer.
- 14.2 Taser data should be downloaded on a monthly basis. This information will be retained to provide an audit trail of the activation of each Taser.

15 Storage and Health and Safety

- 15.1 Health and Safety Legislation, in particular the Health and Safety at Work Act 1974 and the Management of the Health and Safety at Work Regulations 1999, and the legislation that extends this to the Police Service, the Police (Health and Safety) Act 1997 and Management of Health and Safety in the Police Regulations 1999, puts an onus on the employer (the force using the Taser) to carry out risk assessments and develop safe systems of work as part of an overall process to manage Health and Safety, both for the staff and members of the public, where a duty of care is owed.

- 15.2 A generic risk assessment covering the use of the Taser is attached at Appendix 'F'. This should be considered a base document that individual forces can expand on to reflect the circumstances in which they intend to use the Taser. Matters that need to be considered for an individual force's specific risk assessment are likely to include things such as storage and carriage arrangements.
- 15.3 One specific risk worth drawing attention to here is that electrical devices should not be stored alongside pyrotechnics, ammunition, specialist munitions or flammable products.
- 15.4 In addition, the manufacturer's guidelines for storage of the Taser should be considered.
- 15.5 A comprehensive list of Health and Safety legislation is provided at Appendix 'G'.

Appendix A

Association of Chief Police Officers Extended trial - Operational deployment of Taser

Cross Border Protocols

The current situation is that all Forces have equipped officers with Taser for use as a less lethal option alongside conventional firearms. Only the 5 identified Forces participating in the extended deployment trial have been given authority to deploy Taser to other conflict management situations. On borders of Forces, it is not uncommon for officers to cross boundaries when operationally necessary. With the likelihood of mutual aid between Forces the current cross border protocol should be extended to take account of this trial in those regions affected. It is clear that the Chief Constable of each Constabulary has a duty of care to their officers regardless of whether they are operating within their own Force boundaries or in adjacent Force areas. If supported within the region and in order to achieve a unified approach to this issue, the following draft protocol is proposed:

“It is agreed that the Chief Constable of a Constabulary has a duty of care to their officers, regardless of whether they are operating within their own or other force areas. It is agreed, therefore, that Forces will allow the carriage and operational use of the Taser, as per national guidance in line with the Conflict Management Model”

ACPO Conflict Management, July 2006

DSAC Sub-committee on the Medical Implications of Less-lethal Weapons (DOMILL).

Statement on the medical implications of M26 and X26 Taser use at incidents where firearms authority has not been granted.

Background

1. The DSAC¹ Sub-committee on the Medical Implications of Less-lethal Weapons (DOMILL) was requested by the Home Office to prepare this statement on the medical implications of the proposed extended use of M26 and X26 Tasers by Authorised Firearms Officers (AFOs) and by members of Specially Trained Units (STUs)².
2. In 2003, a trial assessed the use of the M26 Taser as a less-lethal option alongside conventional firearms at incidents where firearms authority had been granted. The trial commenced in April 2003 and lasted for a period of 12 months. Prior to the commencement of the trial, DOMILL produced a statement for Ministers on the medical implications of the use of the M26 in this scenario³. Following independent evaluation, the Home Secretary authorised the M26 Taser for all police forces as a less-lethal option for police operations involving the deployment of AFOs with firearms authority.
3. DOMILL issued a second statement on the M26 Taser in July 2004⁴. This statement reviewed further research recommended by DOMILL and undertaken by the Defence Science and Technology Laboratory (DSTL). In March 2005, a third statement reviewed the medical implications of the use of the X26 Taser, a replacement for the M26 Taser⁵.
4. All statements to date have addressed use of the Taser solely by AFOs at incidents where firearms authority had been granted.
5. The Association of Chief Police Officers (ACPO) examined all uses of the Tasers and concluded that an extension would be appropriate to other conflict management situations where the criteria to authorise the issue of firearms were not met. A submission was presented to the Home Office seeking an extension to the operational deployment of Tasers outside the firearms criteria at incidents involving violence, or threats of violence, of such severity that officers would need to use force to protect the public, themselves or the subject.
6. It is proposed that two groups of police officers would be authorised to use Tasers in non-firearms incidents: AFOs and members of STUs. Policy and Guidance have been written for use of the Taser by each group at incidents involving violence, or threats of violence, of such severity that officers would need to use force outside firearms authority to control the situation.

¹ Defence Scientific Advisory Council – a non-departmental public body of the Ministry of Defence.

² "Specially Trained Units" comprise police officers who are selected and trained in the use of Tasers at non-firearms incidents, within the relevant Policy and Guidance. The unit may or may not contain Authorised Firearms Officers.

³ DSAC Sub-committee on the Medical Implications of Less-lethal Weapons (DOMILL). Statement on the medical implications of the use of the M26 Advanced Taser. DSTL/CBS/BTP/PAT-ACPO/MAN/REP/4 dated 9 Dec 02.

⁴ DSAC Sub-committee on the Medical Implications of Less-lethal Weapons (DOMILL). Second statement on the medical implications of the use of the M26 Advanced Taser (July 2004). DSTL/CBS/BTP/PAT-ACPO/MAN/REP/4 dated 27 Jul 04.

⁵ DSAC Sub-committee on the Medical Implications of Less-lethal Weapons (DOMILL). Statement on the comparative medical implications of the use of the X26 Taser and the M26 Advanced Taser. DSTL/BSC/DOC/803 dated 7 Mar 05.

7. This statement presents the view of DOMILL on the medical implications of the proposed extended Taser use and is based on the evidence presented to it by DSTL.

Technical approach

8. DOMILL has reviewed:
 - a. the two draft Policy and Guidance documents for AFOs and STUs;
 - b. the scope of the Taser training modules for the STUs, and their alignment to those applicable to AFOs;
 - c. advice from ACPO on the criteria for selection of officers for membership of the STUs;
 - d. Taser Evaluation Forms and a small number of Forensic Medical Examiners' (FME) reports for nearly all uses of Taser within the period April 2004 to December 2006;
 - e. the medical risk factors declared in the Guidance;
 - f. the medical advice notes to the subject, the subject's general practitioner and to hospitals;
 - g. a recent interim review by DSTL on the possibility of increased risks to the hearts of children and adults of small stature from the electrical currents flowing in the chest.
9. DOMILL has sought advice from ACPO on the likely population characteristics of those who may be subjected to Tasers at incidents where firearms authority would not be granted. ACPO advised that the proposed extension to use of the Taser is unlikely to alter the population make-up of those against whom the Taser is deployed. Specifically, ACPO does not anticipate that the proportion of children and persons under the influence of illicit drugs, alcohol or other intoxicants will change following implementation of extended use. It is likely that the numbers of people subjected to Taser will increase.

Conclusions

10. The new Policy, Guidance and training modules appear robust and, for both AFOs and members of STUs, they appear to provide a common foundation to minimise the potential for adverse medical effects from use of the M26 and X26 Tasers in non-firearms incidents.
11. The more frequent use of the Taser will result in a greater annual incidence of minor injuries and a greater, but still low, chance of a serious adverse event.
12. DOMILL anticipates that there will be an increase in the numbers of children subjected to Taser. DOMILL has reviewed ten cases of the exposure of persons under the age of eighteen to Taser currents in Great Britain up to December 2006, under firearms authority. The medical effects reported that could be attributed directly to the Taser were the expected minor wounds from the probe barbs.

13. There is very limited information globally on the relative vulnerability of children to Tasers, from either operational data or experimental studies on animals. However, data from McDaniel *et al.*⁶ on the reduction in the safety factor for initiation of a serious cardiac event (ventricular fibrillation) with a reduction in the body weight of pigs suggests, if extrapolated to humans, that the safety factor for induction of ventricular fibrillation by Taser discharge in children at the younger (i.e. smaller) range of the paediatric population may be lower compared with that in the adult population. Until more research is undertaken to clarify the vulnerability of children to Taser currents, children and persons of small stature should be considered at possible greater risk than adults and this should be stated in the Guidance and training modules⁷.
14. The review of the Taser Evaluation Forms and the available (legible) FME reports showed no unexpected injuries in over 200 persons subjected to Taser currents. Most of the injuries reported arose from falls (anticipated from the previous DOMILL statements) or were not directly associated with Taser use.

Recommendations

15. Due to the paucity of Taser deployment data against smaller individuals, together with suggestive evidence from limited animal studies, DOMILL recommends that AFOs and members of STUs should be particularly vigilant for any Taser-induced adverse responses in this subset of the population.
16. The Guidance should be amended to identify children and adults of small stature as being at potentially greater risk from the cardiac effects of Taser currents than normal adults of average or large stature.
17. In view of the uncertainties in the population characteristics of the increased numbers of subjects who are likely to be affected by the extended use of the Taser, it is essential that a quarterly review of Taser Evaluations Forms is undertaken by ACPO, DSTL and the Home Office. The acceptability of reversion to annual reporting should be assessed after the first year and DOMILL should be consulted. The Taser Evaluation Forms should identify under which policy authority the Taser was used.
18. DOMILL should be advised immediately in the event of any moderate or serious injuries or adverse physiological responses occurring directly or indirectly from firing of a Taser.

Chairman, DOMILL.

⁶ McDaniel, W.C. *et al.* (2005). Cardiac safety of neuromuscular incapacitating defensive devices. *PACE*, **28** (Suppl 1):S284-S287.

⁷ DOMILL has been requested by the Northern Ireland Policing Minister to identify essential studies that would enhance DOMILL's confidence in their developing views on whether children and vulnerable adults are likely to be at greater risk from the adverse effects of Taser, than normal adults.



Association of Chief Police Officers – Operational deployment of Taser

Information leaflet for persons upon whom a Taser has been used.

You have been subjected to the effects of a Taser. The Taser passed short pulses of electricity into your body. The electricity made your muscles contract. You may have lost balance and fallen to the ground.

The device was used by a specially trained police officer.

During, or shortly after the use of the Taser, you may have experienced the following:

- Being dazed for several minutes;
- Muscle twitches;
- Loss of memory of the event;
- Unsteadiness, and a spinning sensation;
- Temporary tingling;
- Weakness in the limbs;
- Local aches and pains, and tissue swelling.

These sensations are normal effects of the Taser.

If any of these effects are still present a day later, see a doctor.

You may have two small marks (like bee stings) in your skin. These are small puncture wounds from the short needles used to inject the electricity directly into your skin. There may be small burns similar to sunburn around these marks. These should return to normal in a few days. If they do not and there is pain and swelling, you may have a local infection – see a doctor. If the probes only stuck in your clothing, you may still have two small areas of skin underneath that look sunburned.



Association of Chief Police Officers – Operational deployment of Taser

Information for General Practitioners

Introduction

The Police have commenced the operational deployment of Taser and are undertaking an extended operational trial in this area. This equipment has been made available to specially trained officers only.

Tasers are hand-held devices that fire two barbs at an individual. The barbs are intended to attach to the skin or clothing on the torso and/or lower limbs. The barbs are attached to the Taser handset by thin wires. A sequence of very short duration high voltage current pulses passes through wires connecting the handset to the barbs. The current flows into the body and results in a loss of muscular control and in pain. The device also enables direct contact of the Taser handset to the surface of an individual; two closely spaced fixed electrodes pass the current pulses into the subject. This manner of application is usually classed as use in “stun” or “probe” mode; pain is the principal local physiological effect.

The police use X26 and M26 (26 watt) Tasers, which have been available operationally within the UK since 2003 and in use on volunteers and operationally for several years before that in the US and Canada. Prior to this, lower power Tasers were used in North America for about 20 years.

The medical implications of use of the Taser, in the operational trial by the Police, have been reviewed by an independent panel of clinicians, and their statement was part of the evidence considered by Government prior to the decision to authorise the adoption of Taser by the police and for this extended trial.

Classification of injuries

Unintended adverse effects from the use of Tasers may be classed thus:

- Primary: immediate or delayed consequences of electrophysiological phenomena resulting directly from the current flow in the body; it is surmised from the known effects of electric fields and currents on the body (for example, lightning, electric fence controllers) that the organ of principal concern is the heart;

- Secondary: physical trauma directly associated with Taser use, principally injuries from falls; the head is the principal area at risk;
- Coincidental: injuries received in the incident not directly related to Taser use e.g. baton use, self-inflicted wounds, gunshot wounds.

Life-threatening and serious injuries

The risk of life-threatening injuries and of other serious injuries, such as the loss of an eye, is considered to be very low. The intuitive high risk of serious head injury from an uncontrolled collapse is not manifested in practice; most subjects apparently collapse in a semi-controlled manner. A number of deaths have occurred in the North America during (or after) the use of Tasers; the deaths were principally attributed to illegal drugs consumed by the subjects, or to physiological manifestations of severe exercise and restraint, frequently compounded by drug use or cardiac disease. There has not been a death unequivocally attributable to the primary effects of a Taser.

Other effects

Falls may result in abrasions, scratches, minor lacerations, swellings and areas of redness on the skin. Minor secondary trauma from the penetration of the skin by the barbs will occur. Some of the barb penetrations will exhibit small circular burns; areas of skin where current has entered the body from barbs retained in clothing may also exhibit burns. These burns are likely to resolve within a few days, without complications. The barbs will have been removed by medical staff; they were 8 mm in length with a 1 mm high barb about 3 mm from the tip. They were not “fish-hooked” in shape.

There is no evidence of any long-term clinical effect of Taser use.

Pacemakers

The evidence for the damage or disturbance to implanted electrical equipment such as pacemakers is limited and equivocal - be aware of the potential risk of damage to the device.

Use in Great Britain

Up to the end of December 2006, over 200 persons had been subjected to the Taser in GB. There were no serious or unexpected medical consequences. All uses of Taser are reviewed by the independent medical panel.

**For additional information
Please Contact**

***** *Police Station/HQ* *****
***** *Telephone Number* *****



Association of Chief Police Officers – Operational deployment of Taser

Information for hospitals regarding the medical implications of the use of the Taser on subjects

Introduction

The Police have commenced the operational deployment of Taser and are undertaking an extended trial in this area. This equipment has been made available to specially trained officers only.

Tasers are hand-held devices that propel two barbs at an individual. The barbs are intended to attach to the skin or clothing on the torso and/or lower limbs. The barbs are attached to the Taser handset by thin wires. A sequence of very short duration high voltage current pulses passes through wires connecting the handset to the barbs. The current flows into the body and results in a loss of muscular control and in pain. The device also enables direct contact of the Taser handset to the surface of an individual; two closely spaced fixed electrodes pass the current pulses into the subject. This manner of application is usually classed as use in “stun” or “probe” mode; pain is the principal local physiological effect.

Tasers have been classed as “low-power” (5-7 Watt) or “high-power” (14-26 Watt). Tasers have been in use for over 20 years, principally in the US. High-power Tasers have been available and in use on volunteers and operationally for several years in the US and Canada; the Tasers in use in the UK are classed as high-power and are principally the type X26¹².

The medical implications of use of the Taser, in the initial operational trial by the Police have been reviewed by an independent panel of clinicians, and their statement was part of the evidence considered by Government prior to the decision to authorise the adoption of Taser by police and for this extended trial.

The independent panel of clinicians has also reviewed all cases of use of the Taser since the commencement of operational use by Authorised Firearms Officers in April 2004.

¹² www.taser.com

Classification of injuries

Unintended adverse effects from the use of Tasers may be classed thus:

- Primary: immediate or delayed consequences of electrophysiological phenomena resulting directly from the current flow in the body; it is surmised from the known effects of electric fields and currents on the body (for example, lightning, electric fence controllers) that the organ of principal concern is the heart;
- Secondary: physical trauma directly associated with Taser use, principally injuries from falls; the head is the principal area at risk;
- Coincidental: injuries received in the incident not directly related to Taser use e.g. baton use, self-inflicted wounds, gunshot wounds.

It is notable that in two surveys from law-enforcement agencies in North America, more than half of the number of people confronted with the Taser were impaired by alcohol, drugs or mental illness. Some drugs and the metabolic consequences of muscular activity are believed to increase the susceptibility of the heart to potentially life-threatening arrhythmias. Experience in Great Britain also confirms that a significant proportion of subjects are intoxicated by illegal drugs or alcohol.

Deaths

Over the period of use of low-power Tasers, there were a small number of deaths associated with a large number of operational uses. Kornblum and Reedy discuss 16 deaths over a 4-year period in Los Angeles¹³. Other factors such as pre-existing heart disease and drug use were implicated in these deaths. The time interval between Taser application and death ranged from 15 min. to 3 days; 5 deaths occurred at 15 min., 3 at 30 min. and 3 at 45 min. On the available evidence, it is considered extremely unlikely that a death from primary injuries has been caused by a low-power Taser.

With regard to the high-power X26 and M26 Tasers, the risk of death from primary injury is low and in common with low-power Tasers, is certainly very much lower than that from conventional firearms. A small number of deaths has been reported to be associated with (but not necessarily caused directly by) use of the X26 and M26 Tasers. A report in 2004 by Amnesty International discusses deaths associated with Taser use¹⁴.

There is considerable debate on the cause of death in fatalities arising during or subsequent to restraint and arrest in incidents involving Taser application. Although this is disputed in some quarters, the deaths are principally attributed by medical examiners to illegal drugs consumed by the subjects, or to physiological manifestations of severe exercise and restraint, frequently compounded by drug use

¹³ Kornblum RH, Reedy SK (1991). Effects of the Taser in fatalities involving police confrontation. *J Forensic Sci.* Vol 36, 434-448. For a rebuttal of some of the conclusions of this paper, see Allen TB (1992). Discussion of "Effects of the Taser in fatalities involving police confrontation". Letter to Editor. *J Forensic Sci.* Vol 37, 956-958.

¹⁴ [http://web.amnesty.org/library/pdf/AMR511392004ENGLISH/\\$File/AMR5113904.pdf](http://web.amnesty.org/library/pdf/AMR511392004ENGLISH/$File/AMR5113904.pdf)

or cardiac disease. The view of the independent medical panel in the UK is that there has not been a death unequivocally attributable to the primary effects of a Taser.

Deaths arising from the secondary consequences of Taser use have not been reported.

Life-threatening and serious injuries

The risk of life-threatening injuries and of other serious injuries, such as the loss of an eye, is very low. The probability of impact of a barb on the surface of the eye is considered to be low. The impact of barbs on the head has occurred operationally; non-operational evaluation trials on targets have also resulted in head impacts.

The intuitive high risk of serious head injury from an uncontrolled collapse is not manifested in practice; most subjects apparently collapse in a semi-controlled manner.

Other effects

Falls may result in abrasions, scratches, minor lacerations, swellings and areas of redness on the skin. Minor secondary trauma from the penetration of the skin by the barbs will occur. Some of the barb penetrations will exhibit small circular burns; areas of skin where current has entered the body from barbs retained in clothing may also exhibit burns. These burns are likely to resolve within a few days, without complications.

Barb removal

The current injection needles are 8 mm in length and have a 1 mm high barb about 3 mm from the tip. They are not "fish-hooked" in shape. It is believed that the normal practice in the US for removal of a barb from torso and limbs is to support the skin around the barb with fingers and withdraw the barb by gentle traction. Removal of barbs from areas such as the face and eye may require advice from appropriate clinical specialists.

Use on drug and cardiac impaired individuals

It is believed that drugs such as cocaine and pre-existing heart disease may lower the threshold for cardiac arrhythmias. Many of the 16 fatalities associated with use of the low-power Tasers in the Los Angeles survey had also taken PCP (phencyclidine) prior to the incident. PCP is also thought to be pro-arrhythmogenic but is infrequently encountered as a substance of abuse in the UK.

There is no experimental evidence that the aforementioned pro-arrhythmic factors increase the susceptibility of the heart to low or high power Tasers specifically, sufficient to cause an arrhythmic event. Nevertheless, there is sufficient indication from the forensic data and the known electrophysiological characteristics of the heart (and the effects of certain drugs on this) to express a view that excited, intoxicated individuals or those with pre-existing heart disease could be more prone to adverse effects from the high power Taser, compared with unimpaired individuals.

Admission for observation may be advisable.

Acidosis

Fish and Geddes¹⁵ discuss the metabolic consequences of Taser use and the metabolic status of agitated or intoxicated individuals on whom the Taser may be used. Specifically, metabolic acidosis arising from physical activity (or clinical conditions) may increase the potential for ventricular arrhythmias particularly in the presence of phencyclidine and cocaine. Although individuals in a quiescent, relaxed state after Taser use and exertion would be expected to compensate the metabolic acidosis quickly, those that remain agitated or are restrained in a way that could compromise normal breathing may remain vulnerable from potentially fatal quantities of ingested drugs. They recommend that the acid-base status of patients subjected to Taser should be checked if they are agitated or unwell, and steps should be taken to restore the normal status.

Pacemakers

The evidence for the damage or disturbance to implanted electrical equipment such as pacemakers is limited and equivocal – be aware of the potential risk of damage to the device.

Use in Great Britain

Up to the end of December 2006, over 200 persons had been subjected to the Taser in GB. There were no serious or unexpected medical consequences. All uses of Taser are reviewed by the independent medical panel.

For additional information Please Contact

***** *Police Station/HQ* *****

***** *Telephone Number* *****

¹⁵ Fish R, Geddes LA (2001). Effects of stun guns and tasers. Lancet; Vol 358; 687-689.

**Risk Assessment
Taser Use**

Taser

Appendix F

WORK ACTIVITY		HAZARD	RISK (H-M-L)	CONTROL MEASURES REQUIRED	IN PLACE	FURTHER ACTION REQUIRED	
Ref. No	Description					By When	Person Responsible
1.	Taser Use	Injury to body from probes. Injury from falling due to incapacitation, ignition of flammable material by spark. Injury to eyes caused by laser sighting device.	<u>M</u>	Only trained staff to instruct the use of Taser, in accordance with the ACPO National Taser Training package. Only authorised staff to use operationally	ACPO Training Package	Review GRA Annually	By senior firearms officer
2.	Control of Taser and Cartridges	Malfunction of Taser or cartridge leading to explosion or unexpected discharge	L	Taser and cartridge to be maintained in accordance with the manufacturer's instructions and regularly inspected. Taser to be kept pointed in a safe direction. Taser should be kept securely when not in use. Taser and cartridges showing signs of wear and damage should be removed from use	National Policy on Inspection and Maintenance		

Appendix F

Risk Assessment Taser
Taser Training

WORK ACTIVITY		HAZARD	RISK (H-M-L)	CONTROL MEASURES REQUIRED	IN PLACE	FURTHER ACTION REQUIRED	
Ref. No	Description					By When	Person Responsible
1.	Taser Training	Injury to body from probes. Injury from falling due to incapacitation, ignition of flammable material by spark. Injury to eyes caused by laser sighting device.	M	Only trained staff to instruct in the use of Taser, in accordance with the ACPO National Training package.	ACPO Training Package	Review GRA Annually	By senior firearms officer
2.	Control of Taser and Cartridges	Malfunction of Taser or cartridge leading to explosion or unexpected discharge		Taser and cartridge to be maintained in accordance with the manufacturer's instructions and regularly inspected. Taser to be kept pointed in a safe direction. Taser and cartridges showing signs of wear or damage should be removed from use	National Policy on Inspection and Maintenance		

3.	Tactical training	Eye injuries from cartridge discharges at close quarters Injury to eyes caused by laser sighting device.	M	Provide students with suitable eye protection, and require it to be worn			
4.	Control of Taser and cartridge during training	Risk of being effected by training cartridge (Blue) being mixed with live cartridge (Black and Yellow)	L	Ensure that all live cartridges are removed prior to commencement of training All Tasers to be proved to be unloaded prior to issue of training rounds Student and instructor to visually check rounds are training rounds before issue			

Relevant Health and Safety at Work Legislation.

Health and Safety at work Legislation.

Since 1 July 1998, all police activities have been subject to health and safety at work legislation. This legislation is criminal law and breach of the legislation can result in criminal prosecution by the Health and Safety Executive (HSE) who are the enforcing authority.

The main pieces of health and safety legislation that cover the use of less lethal options are:-

- The Health and Safety at Work etc. Act 1974
- The First Aid at Work Regulations 1989
- The Electricity at Work Regulation 1989
- The Personal Protective Equipment (PPE) Regulations 1992
- The Manual Handling Operations Regulations 1999
- The Police Health and Safety Act 1997
- The Provision and Use of Work Equipment Regulations 1998
- The Control of Substances Hazardous to Health (COSHH) Regulations 2002
- The Management of Health and Safety at Work Regulations 1999
- The Pressure Systems Safety Regulations 2000
- Workplace (Health Safety and Welfare) Regulations 1992
- Work at Height Regulations 2005
- Dangerous Substances and Explosive Atmospheres Regulations 2002
- Reporting of Injuries Diseases and Dangerous Occurrences Regulations 1995

All near misses/ accidents in the workplace should be reported via force reporting systems.

Appendix H

- See Taser Deployment Form (V8 July2007) word document.

Selection and refresher training

Members of Specially Trained Units (STUs):-

- 1) Should possess sound judgement, a knowledge and understanding of the Conflict Management Model to resolve incidents involving conflict, have demonstrated maturity of action in the workplace, demonstrated an ability to use legitimate force in a proportionate manner and have an acceptable Professional Standards / Complaints and Misconduct record. (There is no requirement for psychological profiling to be used for selection.) This being signed off by an officer of at least the rank of Superintendent.
- 2) Will have been confirmed in the rank of Constable (in future SOCA equivalent).
- 3) Will be expected to undergo an annual eyesight test in the same way that authorised firearms officers do, governed by local force policy and procedures.
- 4) Will be expected to be able to discharge a Taser accurately, pass the final examination at the end of the course, demonstrate competence at dealing with role-play scenarios in training and have knowledge and an understanding of; the Conflict Management Model and dealing with vulnerable persons.
- 5) Will be required to successfully complete annual refresher training. If they are found not to be competent during re-training / re-accreditation must take place or they will leave this role.

All Police Trainers are assessed as being competent through the annual PDR (Performance, Development & Review Process). Taser trainer/s must have Occupational Competence (successfully completed the ACPO sponsored Taser training package) and Operational Competence (demonstrated that ability in an operational arena).