Post-Force Medical Aid

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What It Is

Once force has been used, a separate constitutional question arises: what obligation do officers have to obtain or provide medical assistance? The Supreme Court established the basic rule in *City of Revere v. Massachusetts General Hospital* (1983): the Due Process Clause requires government to provide medical care to a person injured during apprehension by police. A shooting may be constitutionally reasonable and still be followed by constitutionally deficient medical care.

These two questions – was the force reasonable, and was the subsequent medical response adequate – are analytically independent. In edged-weapon encounters that result in gunshot wounds, this means the force analysis and the medical-care analysis must be conducted separately even when they arise from the same incident.

The Basic Obligation

The constitutional obligation is to ensure that necessary medical care is actually obtained. Officers satisfy this requirement by calling EMS promptly, facilitating paramedic access, and not obstructing or delaying the response. The Constitution does not require officers to personally perform CPR, pack wounds, or administer any specific treatment in every case. *Maddox v. City of Los Angeles* (9th Cir. 1986) established that the duty is to secure care, not necessarily to personally deliver it. *Tatum v. City & County of San Francisco* (9th Cir. 2006) held that promptly summoning an ambulance and monitoring the subject while waiting satisfies the constitutional floor.

But calling EMS is the beginning of the obligation, not the end. *Penilla v. City of Huntington Park* (9th Cir. 1997) held that officers who cancelled an existing 911 medical request, moved a seriously ill man indoors, locked the door, and left potentially created liability because their affirmative actions obstructed care that was already coming. The obligation is not discharged by a nominal EMS call followed by conduct that prevents effective response.

Scene Safety and the Timing of Aid

Officers who have just used force may not have immediate access to the subject. The person may still be armed, may be unresponsive in a position that requires clearing, may be in a location that creates safety risk for paramedics, or may be one of multiple subjects requiring attention. Reasonable scene-safety measures before

medical access – confirming weapon status, handcuffing, coordinated approach – are not themselves constitutional violations.

The constitutional issue arises when delay continues after the threat is controlled. A person who has been shot, is on the ground, is surrounded by officers, has been handcuffed, and has had the weapon secured presents no ongoing threat justifying continued delay in medical response. At that point, the scene-safety rationale has run its course.

For edged-weapon encounters specifically: a person who has been shot and is on the ground may still be within reach of a knife. Reasonable safety steps – commanding the person to show hands, securing the knife, positioning officers at a safe angle – can coexist with initiating medical response. They do not require choosing between officer safety and prompt care.

Delay Can Be Constitutionally Significant

Delay is not automatically a constitutional violation, but it can be. Courts examine the seriousness and obviousness of the injury, the length of delay, the reason offered for delay, whether the person deteriorated during the delay, whether officers had reason to observe that deterioration, and whether the delay caused additional harm. Unexplained delay after the scene is safe and the threat is controlled looks different from a brief delay while officers confirm weapon status.

For gunshot wounds – which are externally visible, obviously serious, and rapidly deteriorating – the medical need is not ambiguous. Officers who observe a person bleeding heavily and take no action to summon care have not made a difficult medical judgment; they have made an observable choice about a serious injury.

The Governing Standard: A Circuit Split

The constitutional culpability standard for medical-care failures depends on the subject's status and the circuit:

Fourth Amendment (post-arrest, pre-detention). Some circuits, particularly the Ninth, apply a Fourth Amendment objective-reasonableness standard to the period immediately following arrest: did officers provide objectively reasonable post-arrest care?

Fourteenth Amendment, objective standard. After *Kingsley v. Hendrickson* (2015), the Second, Fourth, Sixth, Seventh, and Ninth Circuits apply a materially objective standard to pretrial-detainee medical-care claims: did the official know or reasonably should have known of an unjustifiably high risk and act or fail to act unreasonably?

Fourteenth Amendment, subjective standard. The First, Fifth, Eighth, Tenth, and Eleventh Circuits retain the *Farmer v. Brennan* subjective deliberate-indifference standard: the official must have actually known of and consciously disregarded the serious medical risk.

The practical significance: in an objective-standard circuit, the question is what a reasonable officer should have recognized. In a subjective-standard circuit, the plaintiff must prove this officer actually knew and chose to disregard the risk. The same facts can produce different outcomes depending on jurisdiction.

Self-Inflicted Injury

The constitutional duty is not limited to injuries caused by officers. If a suicidal person has cut themselves, stabbed themselves, or overdosed before or during police contact, and officers are present, aware of the injury, and have custody or control of the scene, the same medical-care analysis applies. The government's obligation to provide necessary medical care arises from custody and knowledge of the need – not from whether officers caused the injury.

Continued Restraint During Medical Distress

Some incidents involve overlapping theories. A person who is handcuffed in prone restraint and shows signs of medical distress – difficulty breathing, cyanosis, loss of responsiveness, abnormal sounds – presents both a force question (is continued prone restraint now excessive?) and a medical-care question (are officers responding to an obvious medical emergency?). Courts have found that continued mechanical restraint during obvious medical distress can independently support both excessive-force and failure-to-provide-care claims.

Officers should be trained to distinguish between a restrained but stable subject and a restrained subject who is deteriorating. Placing someone in restraint and leaving them unmonitored is not the same constitutional posture as actively observing obvious distress and failing to respond.

Policy Implications

1. Define the transition from threat control to medical care as a distinct supervisory responsibility. Supervisors at use-of-force scenes should have an explicit function: once the scene is controlled, shift immediately to securing medical response. This does not happen automatically and should not depend on individual officer initiative.
2. EMS staging should be standard, not reactive. For calls involving a reported weapon or known threat of force, EMS staging nearby – ready to enter as soon as the scene is controlled – reduces the gap

between force and care. Calling EMS after force has already been used creates a response-time lag during the period of greatest medical urgency.

3. Officers should communicate force mechanisms to medical personnel. Number of apparent gunshot wounds, location of impact, deployed less-lethal devices (probe locations for CEW, impact areas for kinetic rounds), and restraint position all affect the medical response. Withholding this information or providing inaccurate information to paramedics can independently contribute to inadequate care.
4. Body-worn cameras should continue recording through the medical response. Analysis of post-force conduct – delay, restraint positioning, response to deterioration, communication with EMS – depends on this record. Deactivating BWC after force but before the subject is transported creates an evidentiary gap exactly where constitutional medical-care questions arise.
5. Treat the force-to-care timeline as a reportable metric. Agencies that measure time from force to EMS call, time from EMS call to EMS arrival, and time from EMS arrival to EMS access can evaluate whether systematic patterns in their post-incident response create constitutional or operational risk. Agencies that do not capture this data cannot identify problems until litigation reveals them.

HOW TO CITE

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