King County

Office of Law Enforcement Oversight (OLEO)

Date: October 26, 2020

To: Sheriff Mitzi Johanknecht, King County Sheriff's Office (KCSO)

From: Adrienne Wat, Interim Director, Office of Law Enforcement Oversight (OLEO)

Re: ART2019-002, OLEO Recommendations following the Critical Incident Review Board

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Introduction

This memo focuses on KCSO's investigative and administrative review mechanisms in response to an incident involving the use of a lateral vascular neck restraint (LVNR). The goal is to assess the objectivity and thoroughness of KCSO's actions in handling the incident and to provide recommendations based on that analysis.

This memo summarizes the incident based on information obtained from the investigative file. It also identifies observed policy, investigative, and training and tactics issues and includes recommendations to address these concerns.

In preparation for drafting this memo, OLEO reviewed the investigative file in IAPro and attended the associated Critical Incident Review Board (CIRB) on September 22, 2020.

Summary of the Incident

On July 22, 2019, Tyrone Adrian was involved in a vehicle collision. After getting into a verbal argument with the driver of the other involved vehicle, Adrian drove away from the collision scene. The driver of the other vehicle called 911 to report a hit and run. Minutes later, Deputy 1 located Adrian and a passenger sitting in the parked vehicle that was running with the driver's side window down at N 165th St and Stone Ave N. Deputy 1 activated his emergency lights and parked his patrol vehicle on the north side of 165th St, blocking Adrian's vehicle. He approached Adrian's vehicle as Deputy 2 arrived. Deputy 1 motioned for Deputy 2 to position his patrol vehicle in a manner that would block Adrian's car to prevent him from fleeing. After parking, Deputy 2 exited his patrol vehicle, and met Deputy 1, who was already at Adrian's driver's side door.

Deputy 1 asked Adrian if he had just been involved in an accident. Adrian responded that he had not. His words were slurred and his eyes were glazed over and dilated, which led Deputy 1 to

believe that Adrian was under the influence of drugs. When Deputy 1 asked for Adrian's identification, he responded that he did not have ID. When Deputy 2 approached, Deputy 1 asked Adrian to remove his keys from the ignition and step out of his vehicle. Adrian refused. Deputy 1 told Adrian that he was being detained and grabbed his left wrist, but Adrian pulled away. Deputy 2 then attempted to grab Adrian's arm to pull him out of the car, but was unsuccessful. Adrian then exited his vehicle on his own, facing Deputy 2 with his hands clinched near his chest. Deputy 1 observed Adrian advance toward Deputy 2, though Deputy 2 did not mention this movement in his written statement. Deputy 1 then attempted to detain Adrian from behind by grabbing his arms, and Deputy 2 grabbed the front of Adrian's body and hit him with three knee strikes, which were ineffective. Deputy 1 then used a neck restraint to shift Adrian's weight backwards and spun him onto his stomach. Deputy 2 had control of Adrian's right arm. Both deputies told Adrian to stop resisting, but he continued to move his left arm under his stomach area. Deputy 1 stated that he feared Adrian might be grabbing for a weapon and within seconds, Deputy 1 applied a LVNR and Adrian stopped resisting and started to snore. Deputy 1 mentioned that it was difficult to control Adrian otherwise due to his size and strength. A third deputy arrived and helped Deputy 1 place Adrian in handcuffs without further incident. When Adrian awoke, he refused medical treatment and said he was "fine." It took four deputies to put Adrian in the patrol vehicle.

Policy Issues

Level of Force Contradiction in General Orders Manual

The Administrative Review Team's (ART's) more robust investigation into this incident was delayed and incomplete because the incident was not initially treated as one involving deadly force. ART and the CIRB members[1] attributed this issue to a newer sergeant, who responded to the scene to investigate the force but did not recognize a higher level of response was required. Although that is one reason for the mistake, competing policy language in the General Orders Manual (GOM) around the use of neck restraints may have also contributed to this oversight.

GOM 6.00.050(5) on use of force restrictions provides that "members shall not make any physical application or maneuver to the neck region that restricts blood or air flow (i.e., choke holds, sleeper holds, carotid submission holds, lateral vascular neck restraint, etc.), ***except as a last resort*** to protect the member(s) or others from an immediate threat of death or serious bodily injury." (Emphasis added.) However, the same provision further states that "[a]ny and all variations of these maneuvers *may* be considered **deadly force** when applied to the neck region." And, at the time of this incident, GOM 6.01.020 required that ART be called out when deadly force is used. However, because GOM 6.00.050(5) indicates that the use of a LVNR "may" be considered deadly force and there appeared to be no injury to Adrian, it was unclear under the policy version at the time whether the incident qualified as deadly force and whether ART should have been called out to the incident.

[1] OLEO is a non-voting member; however, we use "CIRB members" in this memo to describe members that are from KCSO.

Since this incident, KCSO has moved in the right direction by revising its reportable force policy to make clear that a neck restraint is considered deadly force, which requires a higher level of review. See GOM 6.01.015(3). However, the contradiction in the use of force policy regarding whether neck restraints like the LVNR are considered deadly force still remains. This can have practical, investigative, and administrative consequences, some of which were highlighted by this incident. Additionally, the assertion that a neck restraint such as a LVNR *may* be considered deadly force is concerning. This policy language allows for space for the department to determine whether a neck restraint was considered deadly force based on whether or not death resulted or the severity of injury sustained. The outcome of an incident should not determine whether the force option used is considered a use of deadly force. For instance, firing a gun, whether it misses or causes injury to the subject, is a use of deadly force. Similarly, the policy for neck restraints should explicitly be categorized as a deadly force technique and not rely on the outcome of the incident to describe the level of force. Doing so provides deputies with a clear expectation that neck restraints cannot be used unless deadly force is authorized. It also helps ensure that the department reviews this type of force consistently and not based on outcome.

Recommendation 1: Revise the bullet under GOM 6.00.050(5) to "Any and all variations of these maneuvers *shall* be considered **deadly force** when applied to the neck region."

Investigative Issues

Use of Force Reporting and Resulting Shortcomings

The CIRB identified the failure to report this incident as deadly force as the primary issue with this case.[2] The breakdown in reporting led to numerous issues with KCSO's administrative review of this incident, including an incomplete investigation. To begin, although Deputy 1 wrote a use of force statement for the incident, the statement was not included in the administrative file until halfway through the CIRB because it had not been compelled. When ART obtained the statement, it had been over a year since the incident had occurred. This means the captain who initially reviewed the incident found that the LVNR was within policy based only on written statements by witness officers and did not have a detailed account from Deputy 1 as to why he chose to use an LVNR over other less lethal force options. That information is required to determine whether force used was necessary, reasonable, and proportional.

Similarly, the use of force investigation does not include a statement from Adrian or the witness passenger in his vehicle. Failing to interview all of the involved parties, especially the subject of force and witness, results in an investigation that is not thorough and allows conclusions to be drawn from an incomplete picture. During the CIRB, OLEO raised that standard pieces of the investigation were missing, and there was discussion that ART should fill in investigative gaps in

[2] As mentioned above, given the policy contradictions in the GOM, this seems to be more than a reporting issue. Nonetheless, and to its credit, KCSO's eventual interpretation of the policy in this instance triggered a referral to the ART and CIRB, which the following analysis relied upon. Implementing Recommendation 1 would help prevent this issue and ensure that all neck restraints receive the same, higher level of review in the future.

the future. However, there was no discussion by CIRB members about how to address an incomplete investigation for this incident.

Lastly, because the deputy's compelled statement was not included in the administrative file for review prior to the meeting, the CIRB was not given sufficient opportunity to review the statement prior to meeting. The ability to review, digest, and scrutinize information before a meeting where members discuss and vote on questions such as whether force used was within policy is crucial to a thorough review.

Recommendation 2: Implement a formal mechanism for ART to properly conduct a thorough investigation when it was not called out to the scene as required by the GOM.

Recommendation 3: ART should have a protocol for identifying gaps in the investigation prior to the CIRB so that any additional investigation can be conducted before the CIRB commences.

Recommendation 4: Any time deadly force is used, the involved employee shall provide a statement for the administrative investigation through an in-person video recorded interview by the end of their shift.

Training and Tactics Issues

KCSO Does Not Currently Train the LVNR Technique

Deputy 1 reported he was trained on the LVNR technique by a previous employer and KCSO. During the CIRB, information was also provided that Deputy 1 is a former defensive tactics trainer who may have trained others in the use of the LVNR. [3] While this experience may have equipped the deputy with the ability to use the LVNR as trained for a time, the skill is nonetheless perishable. Additionally, there was discussion in the CIRB that the department should refer to this neck restraint as a carotid neck restraint since LVNR is a registered trademark name that requires annual recertification. However, regardless of what KCSO terms the technique, regular training should still occur if deputies are authorized to utilize the force option. This helps ensure that deputies use force techniques and weapons effectively, safely, and to prevent unnecessary liability to KCSO.

Recommendation 5: All force options that are permitted by the GOM shall be regularly trained, at minimum annually, by KCSO.

Use of Deadly Force Justification

In his compelled statement, Deputy 1 stated that he feared Adrian might be grabbing for a weapon as Adrian moved his arm under his stomach and resisted arrest. Deputy 1 also stated that he felt his life was in danger, which is why he ultimately decided to use the LVNR.

[3] Whether a deputy has had training to use an LVNR that results in an outcome like the one in this case must not detract from the CIRB (or any use of force review) task to review specific facts of an incident to determine whether the use of deadly force was authorized.

However, subjects often move their arms to areas out of deputies' reach to resist arrest and there is no indication in the investigative file that the deputies had specific information that Adrian was armed or reaching for the deputy's weapon. Because of that, it is difficult to determine if Adrian's action, by moving his arms under his stomach area, alone rose to a level justifying the LVNR as a last resort to prevent an immediate threat of death or serious bodily injury to the deputies. It is also unclear what standards KCSO uses to differentiate typical resistance from arrest and attempts to produce a weapon.

Recommendation 6: Implement and mandate regular defensive tactics training, which is provided multiple times a year, that includes arrest, control hold, and pain compliance techniques to give deputies more options to eliminate perceived threats posed by arm positioning.

Taser Considerations

In his compelled statement, Deputy 1 stated that he was too close to Adrian to use his taser for anything other than pain compliance. However, it is possible to achieve neuromuscular incapacitation (NMI) from a close range. During taser training, KCSO members are trained that they can deploy probes while in close contact with a subject and follow-up with a drive-stun to close the circuit to achieve NMI. The use of this technique was not considered during this incident, and its use would have been a less lethal option to gain compliance.

Additionally, KCSO's taser coordinator was not consulted during the review of this incident. Although a taser was not used during the incident, Deputy 1 mentioned in his compelled statement that he considered using it. The deputy's explanation for why he determined that the taser was not a viable force option should not be relied upon without obtaining further analysis from someone with qualifying and applicable technical expertise. As KCSO's subject matter expert, the taser coordinator could have been consulted to interpret and/or harmonize policy and practice and to dispute or concur with the deputy's ultimate determination. The taser coordinator could highlight these issues for ART to ask Deputy 1 follow up questions to reach an understanding of what he thought his options were, how he was trained, and why he acted the way he did. This practice would inform and improve training, and provide valuable feedback to the deputy that is both cautionary and reinforces performance requirements and standards. It would also provide the CIRB members with more information for them to determine whether the deadly force option was used as a last resort.

Recommendation 7: KCSO should always consult force option subject matter experts during investigations into incidents where less lethal force options were not used.

List of Recommendations

Recommendation 1: Revise the bullet under GOM 6.00.050(5) to “Any and all variations of these maneuvers *shall* be considered **deadly force** when applied to the neck region.”

Recommendation 2: Implement a formal mechanism for ART to properly conduct a thorough investigation when it was not called out to the scene as required by the GOM.

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