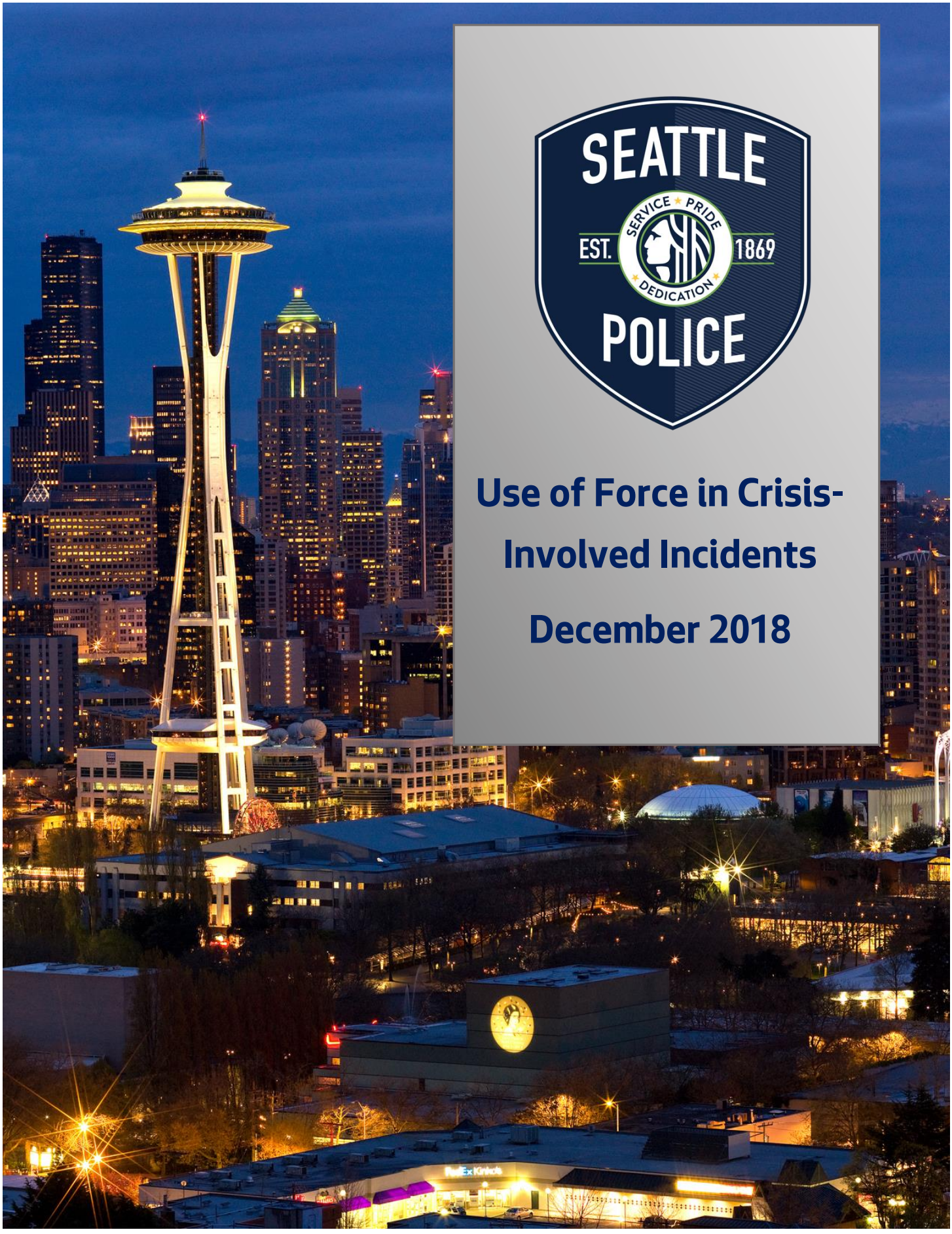

Use of Force in Crisis-Involved Incidents

December 2018

Introduction

On October 31, 2018, the Seattle Police Department released its annual Crisis Intervention Program Report, detailing its responses to the nearly 16,000 crisis-involved calls for service received over the 18-month period between January 1, 2017 and June 30, 2018. This report provided an overview of use of force in crisis incidents, while previewing that a deeper analysis into this topic would follow in a subsequent report. As that report documented, despite the surge in crisis calls overall, the use of force remains empirically rare: Of the nearly 16,000 crisis contacts reported over that 18-month period, reportable force occurred in just 277 (1.7%) of all crisis contacts, and the rate of force remained relatively stable between 1.3% and 1.8%. Further, consistent with prior years' reports, of the overall uses of force occurring during this period, 75% comprised no greater than low-level, Type I force (transient pain such as associated with a soft take-down, handcuffs, or the pointing of a firearm). Five uses of force (.9%) were classified at the highest level, Type III.

While reportable force occurred in just 1.7% of all crisis contacts, these incidents comprise approximately 25% of all use of force – a finding that reflects, across the population of use of force data, subject behavior as the driving factor of the force used. Because these contacts, falling at the intersection of public safety and public health, often volatile and unpredictable, represent among the most tactically challenging incidents to which law enforcement responds, SPD accordingly provides this follow-up report as (1) an aggregated analysis of use of force across multiple metrics in crisis-involved calls, and (2) for each Type II and Type III case during this study period, a qualitative review of the case, the Force Review Board findings, and, where applicable, Office of Professional Accountability findings.

I. Background

A. Use of Force Policies

The Seattle Police Department's Use of Force polices are published, collectively, as Title 8 of the SPD Manual. Policy sections 8.000 through 8.200 set forth the conditions under which force is authorized, when force is prohibited, and affirmative obligations to de-escalate prior to using force, when reasonably safe and feasible to do so, and to assess and modulate force as resistance changes. While recognizing that officers are often forced to make split second decisions, in circumstances that are tense, uncertain, and rapidly evolving, this policy allows officers to use only the force that is objectively

reasonable, necessary, and proportionate to effectively bring an incident or a person under control. Section 8.300 addresses the use and deployment of force tools that are authorized by the Department, such as less-lethal munitions, canine deployment, firearms, OC spray, and vehicle-related force tactics. Section 8.400 prescribes protocols for the reporting and investigation of force; section 8.500 sets forth the process for review of force.

Force is classified, documented, investigated and reviewed according to level of severity, described as below:

De Minimis Force - Physical interaction meant to separate, guide, and/or control without the use of control techniques that are intended to or are reasonably likely to cause any pain or injury. Examples including using hands or equipment to stop, push back, separate or escort, the use of compliance holds without sufficient force to cause pain, and unresisted handcuffing. Officers are not required to report or investigate this level of force.

Type I – Actions which "causes transitory pain, the complaint of transitory pain, disorientation, or intentionally pointing a firearm or bean bag shotgun." This is the most frequently reported level of force. Examples of Type I force, generally used to control a person who is resisting an officer's lawful commands, include "soft takedowns" (controlled placement), strike with sufficient force to cause pain or complaint of pain, or an open hand technique with sufficient force to cause complaint of pain. Type I uses of force are screened by a sergeant and reviewed by the Force Review Unit.

Type II – Force that causes or is reasonably expected to cause physical injury greater than transitory pain but less than great or substantial bodily harm. Examples include a hard take-down or and/or the use of any of the following weapons or instruments: CEW, OC spray, impact weapon, beanbag shotgun, deployment of K-9 with injury or complaint of injury causing less than Type III injury, vehicle, and hobble restraint. An on-scene (where feasible) sergeant collects available video evidence and witness statements; the evidence packet and analysis of the force is reviewed by the Chain of Command and the Force Review Unit (FRU). Cases flagged by the Force Review Unit for further inquiry, in accordance with policy criteria, plus an additional random 10% of Type II cases are also analyzed by the Force Review Board (FRB).

Type III – Force that causes or is reasonably expected to cause great bodily harm, substantial bodily harm, loss of consciousness, or death, and/or the use of neck and

carotid holds, stop sticks for motorcycles, and impact weapon strikes to the head. Type III force is screened on-scene by a sergeant, investigated by the Force Investigation Team (FIT), and analyzed by the FRB.

B. Review of Force

Under Title 8 of SPD's policy manual, all reportable uses of force (Type I, II and III) are thoroughly and critically reviewed, and it is the substantive review of each force case by the chain of command, the Force Review Unit, and the Force Review Board that makes the initial determination as to whether a use of force is in or out of SPD policy. If any reviewer in the chain of command or the FRU, or if the FRB by consensus, finds an indication of a policy violation, whether related to the force or otherwise, that case is required to be referred to the Office of Professional Accountability for further review and a determination about whether there is any policy violation, and if so, the level of recommended discipline. In addition, the OPA Director or his designee sits in on all FRB discussions, and has the prerogative to take for further review any case regardless of whether the FRB separately refers.

As noted above, Type I uses of force are screened by sergeant, reviewed/approved (or, not approved) by the Chain of Command, and reviewed by the Force Review Unit for completeness. While the Chain of Command is responsible for determining whether the force was within policy, these cases do not go through a fuller FRU/FRB review *except* when the use of force is used in an incident in which a higher level of force was also used. In such instances, the Type I force is then reviewed under the higher standards against which Type II or III force is examined.

By policy, the FRB reviews all Type III cases. The FRU, comprising a captain, a lieutenant, a sergeant, and two detectives, reviews all Type II use of force reports. FRU staff and FRB members undertake the same inquiry, and apply the same standard of review, as the FRB when reviewing cases. FRU staff and FRB members attend the same annual training involving the objective analysis of force, which ensures that the FRU is conducting a thorough review of their cases consistent with the reviews conducted by the Board.

Type II cases are sent to the FRB by the FRU when any of the following factors are involved:

- Possibility of misconduct;
- Significant policy, training, equipment, or tactical issues;
- When FIT was contacted for consultation and declined to respond or investigate;

- When less-lethal tools were used on the subject;
- When a canine makes physical contact with the subject;
- When the subject is transported to an emergency room.

All cases not selected for FRB review are reviewed by the FRU detectives and their chain of command. The FRU captain makes the final determination based on the FRU's reviews and recommendations. Bifurcating Type II use of force cases allows the FRB to focus its efforts on the more significant cases, such as Officer Involved Shootings, Type III investigations, and serious Type II cases. Additionally, a random 10% of cases reviewed each month by FRU are presented to the FRB for a second independent review – a mechanism to ensure quality control.

Both FRU answer the core inquiries of (1) whether the force was consistent with policy – including an affirmative obligation to de-escalate when safe and feasible to do so, and if there were issues with the force, whether supervisors appropriately identified those issues. The FRU considers – and the FRB discusses – all pertinent factors surrounding the force, including the tactics used and supervision at the scene. FRB determinations are documented and any issues identified are referred to the appropriate commander for follow-up. If policy violations are suspected, the incident is immediately referred to OPA, or to the chain of command if appropriate under Manual Section 5.002, by the FRB Chair or designee, if not already referred by the reviewing chain of command.[1]

II. Methodology

The aggregated data presented in this report is sourced through the Data Analytics Platform, including fielded data around crisis and use of force incidents and newly including a protocol for capturing and integrating data relating to FRU/FRB reviews.

A. Data Analytics Platform - Background

[1] It is important to understand what an FRB finding means relative to the question as to whether the force was constitutional. By law, whether any use of force is lawful under the Constitution is a case-specific determination, based on the perception of a reasonable officer under the totality of the circumstances present at the time the force is applied, and often a point on which reasonable minds can differ. While the courtroom is generally the forum for determining the *legality* of a use of force, the Force Review Board is a mechanism by which members analyze the broader question of whether the force meets the requirements of policy and training that hold officers to a higher standard of conduct – and care should be taken not to conflate the two. Importantly, SPD policy incorporates both federal and state constitutional thresholds, but holds officers to a substantially higher level of performance and scrutiny consistent with community expectations. Simply put, a finding that force is out of policy does *not* equate to a finding that the force violated the Constitution, but a finding that the force was in policy *does* mean that, in the view of the reviewers, it was also likely lawful.

The DAP consists of three primary and essentially interconnected technical and management systems: 1) a data warehouse, 2) a User Interface (UI), and 3) a system of data governance to assure quality data and analytics. In this environment, data flow from the transactional systems used to support the delivery of police service (Police Data Systems, or PDS), through an Extract Transform and Load (ETL) process, to populate a Data Warehouse (DW) and a user interface (UI) through which information is returned to the field for analysis and use as a supervisory and systems oversight resource.

Police Data Systems (PDS) (e.g. Records Management Systems, Computer Aided Dispatch, etc.) serve to accurately capture a record of activity or behavior in the field, as faithfully as possible. Once an officer enters a record into one of the several PDS used to administer the business, the warehousing process engages to query new and changed records through ETL. This process occurs once a day in the early morning, when load on the servers and infrastructure is at a period low. As it is the nature of policing to evolve records, new information is constantly entered, and as such, data must be updated in the warehouse.

The final phase of the warehousing process populates the UI online data store, Tableau Server, with business translated Tableau Data Source (TDS) for use in analysis. As part of the development process used to construct the DAP, business analysts investigated business processes and captured documentation to assure fidelity and complete understanding of the more than 1400 individual data elements present in the DAP. The most visible application of this documentation is the in semantic layer. Every TDS translates the database names used to make the warehouse operate without conflict, into business names. Each dimension and measure is labeled with an intuitive and unique name that corresponds to a document called the Data Tractability Matrix (DTM) – a catalogue of every data element, its origin, translation, error handling, and eventual business representation in the semantic layer.

The DAP is a business intelligence system built for domain-specific users (e.g. sociologists, criminal justice researchers, psychologists, legal scholars, etc.), professional analysts, and researchers. Once warehoused, documented and presented in the TDS, data are diverted to internal, external and collaborative research projects to better understand the underlying systems, business processes and insights present in the data. Professional researchers and analyst employed by the Department utilize the data to answer ad hoc questions pertinent to public policy or strategic planning, generate special reports on topics involving advanced research methods, and operationalize the insights generated by our network of more than forty researchers around the world.

In addition to contributing to the public policy and strategic planning process with guidance based in an empirical understanding of the business and the environment it operates in, Key Performance Indicators (KPIs) are used to identify, understand, and cycle issues back to the field for near-real-time management. Dashboards are used monitor areas identified for their strategic importance to the Department (*e.g*. interactions with community members in behavioral crisis, use of force, constitutional policing). In addition, specialty units, such as the Crisis Response Unit (CRU), are able to request and operate special reports used to manage their area of the business and general supervision or management tools are provided to promote healthy interactions between supervisor and subordinates.

B. Capturing "Gap" Data Around Force Review

The data flow for processing the reporting, investigation, and review of use of force is processed through commercial off-the-shelf PSD software, IAPro and Blue Team. BlueTeam is a web based application that serves as the central collection point for all Use of Force documentation by the officer using force and the investigating, reviewing, and approving chain of command. Officers enter information about the event in a web form and submit the report to a supervisor for investigation, review and approval by the chain of command. Once the chain completes their documentation, the report is submitted to the Force Review Unit (FRU), at which point the record matriculates from the Blue Team application into IAPro. The DAP runs once a day to collect new and updated records from a variety of transactional systems, including IAPro / BlueTeam. Once the record matriculates from the BlueTeam application into IAPro and is assigned a file number, the DAP consumes the record and relates it to other data held in the warehouse.

In May of 2018, the Department began a rapid development process to create a custom software application to capture *un*structured data relating to force reporting, investigation, and review to allow for heightened transparency and accountability around the administrative processes for critical review of force. The system employs an Oracle database and "front end" in a platform called APEX. The application generates a queue as reports process out of the Blue Team workflow tool. As FRU/FRB conduct oversight and quality control review of the records (through the screenshots captured below), they select the appropriate case in the APEX system and document their review. Once a review is complete and submitted to the database, DAP runs to "pick up" completed reviews and relate them to the more than 1400 individual data elements housed there.

The front-end user interface for data entry around the completeness and quality of force investigation and review is modeled upon forms currently being used in FRU that are

designed to ensure that all Consent Decree, policy elements, and timelines associated with force investigation and review are considered and captured by the FRU. Screenshots of the forms currently in use, which are being used to back-populate the application, are included, with explanation, below. In addition, as automated through the custom application, additional information necessary to contextualize or explain "no" answers (such as would appear in the "notes" column of the template forms) is captured in structured form through drop-down options triggered upon entry of "no" response.

With respect to a qualitative review of force, the front-end user interface for data entry is modeled on paper templates previously used to record the FRU/FRB findings with respect to tactics and decision making and the use of force itself (including an assessment of de-escalation efforts, where safe and feasible). Previously, use of force reviews were closed in IAPro with paper documentation of the force review attached to the case file. While complete, these documents were not searchable, and thus offered limited analytics short of a manual review. By entering this information as structured data in the newly implemented application, SPD is now able to capture in database form the overall approval /disapproval of force at an individual level, as well as information regarding any specific remediation (*i.e.* OPA referral, training, chain of command mentoring).

SPD Manual Section 16.110 requires that officers document all contacts with subjects who are in any type of behavior crisis. Currently, the Versaterm Records Management System (RMS) is configured with a template designed to capture certain data in structured fields. These templates are submitted as "children" of a "parent" report and consumed by the DAP Extract, Transfer, Load (ETL) process. This process updates the DAP's data warehouse with new or changed records daily and renders them for analysis in the Tableau server as a discrete data source and associated attribute of the Use of Force data source. Additionally, these data can be joined with other data sources in ad hoc querying, as needed.

This report presents a deeper review of Type I, II, and III uses of force associated with a crisis event, including an aggregate review of (1) the nature of the force used (including implement, if any) and (2) subject behaviors/resistance across the Type I and Type II classifications of force. The report also compares crisis events to non-crisis events relative to overall use of force across the study period. This report further presents the FRU/FRB qualitative analysis as to those cases reviewed by FRU/FRB during the study period, where both a crisis template and Use of Force report were joined under the same case file.[2] The reader should note that, because this review encompasses only those Type

[2] Due to the limitations of siloed records system capturing use of force and crisis events separately, relationships between crisis and use of force can only be inferred presently through a common report number. A match, involving

I uses of force that were included in force cases classified at a higher level (Type II or III), the numbers reported in this section of the report do not include the majority of the Type I incidents reported in the Department's Crisis Intervention Program Report, published October 31, 2018, and in Section I of this accordingly, will differ in raw number from those reported in other contexts.

For each case in which either the Chain of Command, FRU or FRB, or a third-party sought OPA review of a crisis-related use of force incident, this report provides both (1) a description of the case; (2) the FRB's discussion; and (3) the OPA disposition. In three instances that involved a FIT investigation, the entirety of the FIT Force Investigation Report is included for full context and transparency.

Finally, this report examines a smaller cohort of subjects who, over 2017-2018, presented in three or more crisis incidents, for purposes of examining whether there are any remarkable distinctions in use of force involving these "high utilizers" as compared to the overall population of subjects in crisis/use of force cases.

III. Overview of Use of Force in Crisis-Related Cases

Between January 1, 2017, and June 30, 2018, a total of **1,376,724** SPD officers responded to a total of **638,984** unique calls for service. During this same time period, a total of **1,477** cases were generated involving a reportable use of force by one or more officers. In total, across these **1,477** cases, **2,724** separate uses of force were reported, representing **fewer than one-fifth of one percent (0.19%)** of the **1,376,724** officer dispatches during this study period**.** This reflects a rate that is consistent with prior years' reports. (A more comprehensive discussion of overall use of force will be presented in the Department's upcoming 2018 Use of Force Annual Report, to be published on January 31, 2019.)

Of these **638,984** calls for service, **14,181 (2.22%)** involved one or more subjects reported to be in behavioral crisis, as documented via crisis templates configured in the RMS. In total, **15,995** crises templates were completed across these 14,181 cases (indicating some cases that involved more than one subject in crisis). (As noted in the Department's Annual Crisis Intervention Program Report, published on October 31, 2018, and attached hereto

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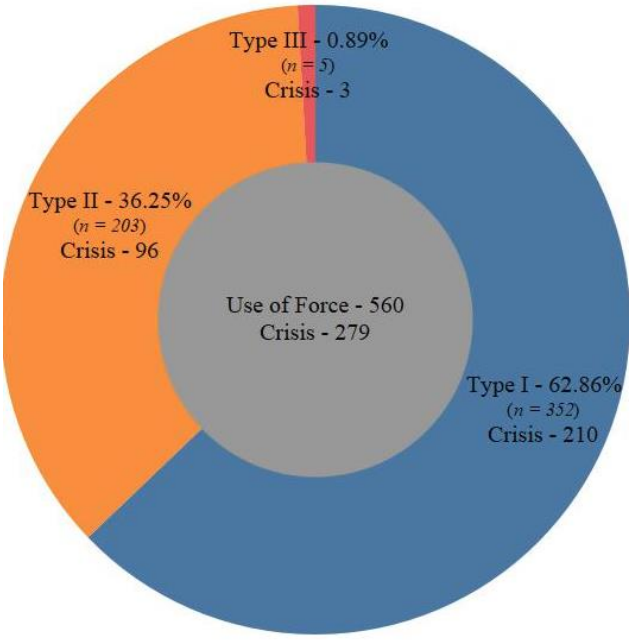
the exact subject of the crisis /use of force is not possible, now. Comparisons made to the Crisis Event and Use of Force data sources suggest just 1 crisis event believed to be associated with a Use of Force f and 3 uses of force believe to include a crisis event, were not included. The observed disparity is due to date filtering, where a Crisis Contact or UoF were reported, associated with a common report, outside the study period. NRMS (MK43) has a UoF reporting capability and is being configured by the NRMS core team, in a feasibility study. De-siloing UoF reporting will improve counts and relationships by joining reports, natively.

as Appendix A for ready reference, these numbers represent a nearly 30% surge in crisis-related calls for service over the past two years.)

Of these **15,995** crisis contacts reported, **279 (1.74%)** (across **274** unique case numbers) involved one or more reportable uses of force.[3] In total, across these **274** cases, **560** separate uses of force were reported. These **560** separate uses of force represent **20.5%** of overall force (across crisis and non-crisis incidents) during the same study period (*n*=2,724).

Figure 1 shows the distribution of force, by Type (I, II or III), across the 560 uses of force in crisis-related incidents.

Figure 1: Distribution of Force in Crisis Incidents



Consistent with rates of force observed across the general population of data, low-level, Type I force continues to represent the largest proportion of overall force – comprising over half (62.86%) of all force used in crisis-related incidents.

Type III (serious use of force) continues to be an empirically rare occurrence, with a total of five uses of Type III force, across three separate incidents, comprising less than one percent (0.89%) of the 560 overall uses of force.[4] Each of these cases is discussed later in this report.

One notable distinction between crisis and non-crisis related use of force incidents is observed with respect to Type II (intermediate) use of force. Whereas, over the past three years, Type II use of force, overall, has remained fairly consistent at around 20% of all use of force, in crisis incidents, Type II force comprises a higher percentage of all use of force

[3] These numbers differ very slightly from those reported on October 31, 2018. The reason for this is that as the DAP, a dynamic system, is updated daily, numbers may change insignificantly from day to day as data is updated. Further, when selecting data from a date range, numbers may change depending on which data source is queried (*e.g.*, use of force cases with associated crisis templates, or crisis templates with an associated use of force report) and the timing of entry of different records into the system. SPD's reporting of Type I and Type II force, accordingly, significantly exceeds that standard. See https://ucr.fbi.gov/use-of-force

[4] Of note, the Department is participating in the FBI's new Use of Force collection program (SPD, in fact, was one of the Departments that participated in the pilot to develop the platform); Type III force is the only level of force that is required to be reported in that platform and is the nationwide standard for "force."

– approximately 36%. This is a real and true difference; whether this observed difference is statistically meaningful is yet to be determined. It is likely that the addition of a subject experiencing apparently behavioral crisis defines a distinct class of force but a statistical approach is required to validate the finding. This will be discussed further later in this report.

Table 1 and 2 shows a breakdown of 2,610 reports, citywide, that contain at least one application of Type I and/or Type II force, by non-crisis/crisis-involved events.

Table 1: Distribution of Type I/II Use of Force, Non-Crisis/Crisis-Involved Events

	Level 1 - Use of Force				Level 2 - Use of Force				Grand Total	
	No Crisis		Crisis		No Crisis		Crisis			
	% of Total	UoF Count	% of Total	UoF Count	% of Total	UoF Count	% of Total	UoF Count	% of Total	UoF Count
Handcuffing	47.06%	815	37.46%	127	13.49%	46	17.68%	35	39.20%	1,023
Control Hold – Restraint	15.59%	270	50.15%	170	33.43%	114	45.45%	90	24.67%	644
Firearm – Pistol – Point	24.54%	425	8.26%	28	4.40%	15	1.52%	3	18.05%	471
Verbal Commands	5.83%	101	6.19%	21	14.08%	48	9.60%	19	7.24%	189
Control Hold – Takedown	2.37%	41	5.01%	17	23.46%	80	21.72%	43	6.93%	181
Control Hold – Team Takedown	2.77%	48	10.91%	37	14.08%	48	21.21%	42	6.70%	175
Firearm – Rifle – Point	7.39%	128	3.24%	11	0.88%	3			5.44%	142
NFDD	2.71%	47	1.47%	5	1.47%	5			2.18%	57
Personal Weapons – Push	1.39%	24	1.18%	4	5.28%	18	5.56%	11	2.18%	57
Electronic Control (ECD / Taser)	0.06%	1			6.74%	23	11.62%	23	1.80%	47
Personal Weapons – Punch/Elbow	0.17%	3	0.29%	1	8.21%	28	7.58%	15	1.80%	47
Personal Weapons – Feet/Leg Kick/Knee	0.17%	3	0.29%	1	7.04%	24	5.05%	10	1.46%	38
Vehicle – Other	0.12%	2	0.59%	2	7.04%	24	5.05%	10	1.46%	38
Chemical Agent – OC Spray					10.26%	35	0.51%	1	1.38%	36
Personal Weapons – Pressure Point	0.29%	5	1.77%	6	1.47%	5	2.53%	5	0.80%	21
Other Weapon - Other	0.23%	4	0.29%	1	2.64%	9			0.54%	14
Canine					3.81%	13			0.50%	13
Firearm – Shotgun – Point	0.52%	9	0.29%	1					0.38%	10
Hobble Restraint			0.29%	1	1.17%	4	2.02%	4	0.34%	9
Personal Weapons – Open Hand Strike	0.12%	2	0.29%	1	1.17%	4	1.01%	2	0.34%	9
Personal Weapons – Feet/Leg Sweep			0.29%	1	0.88%	3	0.51%	1	0.19%	5
Firearm – Pistol – Other	0.23%	4							0.15%	4
Balls - Blast					0.88%	3			0.11%	3
Chemical Agent – Other					0.88%	3			0.11%	3
Vehicle – PIT					0.59%	2			0.08%	2
Baton – Expandable –Control/Pressure Point					0.29%	1			0.04%	1
Baton – Straight –Control/Pressure Point	0.06%	1							0.04%	1
Bicycle – Push					0.29%	1			0.04%	1
Blue Nose Device					0.29%	1			0.04%	1
Carotid/Neck Restraint	0.06%	1							0.04%	1
Other Weapon – Blunt Object							0.51%	1	0.04%	1
Shield							0.51%	1	0.04%	1
Grand Total	100.00%	1,732	100.00%	339	100.00%	341	100.00%	198	100.00%	2,610

Overall, across these 2,610 reports, “Handcuffing” continues to comprise the largest proportion of force applied (39.2% of force overall), followed by “Control Hold – Restraint” (24.67% of total use of force) and “Firearm (Pistol) Point” (18.05% of total uses of force). Of the 32 separate force applications represented in these reports, these three application types were the only to be observed in greater than 10% of force cases, with a sharp (>10%) divide between the third (“Firearm (Pistol) Point”) and fourth (“Verbal Commands”) most frequent force. Only six application types were observed in greater than 5% of reported force, and just 14 application types were observed in at least 1% of reported force.

Some notable distinctions are observed, however, between non-crisis and crisis-involved events. In non-crisis events, “Handcuffing” is the most frequent use of force reported, comprising nearly half (47.06%) of all reported Type I force where no crisis is reported. “Firearm (Pistol) Point” is the second most frequently reported force application within this population of cases (24.54%), followed by “Control Hold – Restraint” (15.59%). In contrast, within the population of crisis-involved events, the “Control Hold – Restraint” is by far the most frequently reported force type (50.15%), followed by “Handcuffing” (37.64%); fewer than 10% (8.26%) involved a “Firearm (Pistol) Point” use of force.

With respect to Type II force cases, “Control Hold – Restraint” is the most frequently reported use of force, comprising 33.43% of all Type II force in non-crisis cases, and 45.45% in crisis-involved cases. “Control Hold – Takedown” and “Control Hold – Team Takedown” are the second and third most frequently reported use of force across both populations, comprising 23.4% and 14.08%, respectively, of Type II force in non-crisis events, and nearly equal proportions (21.72% and 21.21% respectively) of Type II force in crisis-involved events.

Notable differences were observed between the two populations with respect to certain less lethal tools. Specifically, while the number of Taser deployments was equal (n=23) in both non-crisis and crisis-involved events, the proportion of Taser applications was higher in crisis-involved events (11.62%) relative to non-crisis events (5.28%). Only one (0.51% of the total) application of OC spray was deployed in a crisis-involved event, compared to 35 (10.26% of the total) applications of OC spray in non-crisis events. Across both Type I and Type II cases, only two applications of force in non-crisis events involved the use of a baton; there were no reported uses of an impact weapon “strike” in any crisis-involved event during the study period.

Of 2,083 Type I/II use of force reports (overall during the study period) in which at least one type of subject resistance was noted, some similarly notable differences were

observed. A breakdown of subject resistance in Type I/II reports, in both non-crisis and crisis-involved events, is presented in Table 2.

Table 2: Distribution of Subject Resistance in Non-Crisis/Crisis-Involved Use of Force Events

	No Crisis		Crisis		Total	
	% of Total	UoF Count	% of Total	UoF Count	% of Total	UoF Count
Other (Specify in Narrative)	47.69%	753	25.00%	126	42.20%	879
Resist Handcuffing	25.90%	409	45.44%	229	30.63%	638
Passive Noncompliance (including Verbal)	28.50%	450	29.17%	147	28.66%	597
Resist Restraint/Control Hold See above.	18.75%	296	39.88%	201	23.86%	497
Break Free of Control Hold	8.49%	134	14.88%	75	10.03%	209
Personal Weapons – Feet/Leg Kick/Knee	4.88%	77	17.26%	87	7.87%	164
Personal Weapons – Bodyweight	5.89%	93	13.69%	69	7.78%	162
Personal Weapons – Push	3.61%	57	5.75%	29	4.13%	86
Personal Weapons – Punch/Elbow	2.60%	41	8.33%	42	3.98%	83
Control Hold – Restraint	1.90%	30	5.95%	30	2.88%	60
Edged Weapon - Present/Brandish	1.96%	31	4.56%	23	2.59%	54
Control Hold – Takedown	0.82%	13	3.57%	18	1.49%	31
Firearm – Point	1.27%	20	0.60%	3	1.10%	23
Blunt Object – Use	0.89%	14	1.39%	7	1.01%	21
Blunt Object – Brandish	0.44%	7	1.98%	10	0.82%	17
Personal Weapons – Open Hand Strike	0.51%	8	1.79%	9	0.82%	17
Firearm – Fire	0.76%	12			0.58%	12
Edged Weapon – Use	0.19%	3	0.79%	4	0.34%	7
Personal Weapons – Feet/Leg Sweep	0.19%	3	0.40%	2	0.24%	5
Personal Weapons – Pressure Point	0.06%	1	0.20%	1	0.10%	2
Canine	0.06%	1			0.05%	1
Carotid/Neck Restraint			0.20%	1	0.05%	1
Chemical Agent	0.06%	1			0.05%	1
Electrical Weapon (Taser, Stun Gun)	0.06%	1			0.05%	1
Explosive	0.06%	1			0.05%	1
Firearm – Impact Weapon	0.06%	1			0.05%	1
Grand Total	100.00%	1,579	100.00%	504	100.00%	2,083

As was observed with respect to application of force, a review of subject resistance suggests some differences between non-crisis and crisis-involved interactions. In all categories of resistance in which at least one type of resistance was specified (*i.e.*, excluding "other"), the proportions of such resistance were markedly higher in crisis-involved events relative to both non-crisis events and overall use of force. See, in particular, proportions involving "Resist Handcuffing" (45.44% in crisis-involved, compared to 25.9% in non-crisis, events); "Resist Restraint/Control Hold" (39.88% in crisis-involved, compared to 18.75% in non-crisis, events); and "Personal Weapons – Feet/Leg/Kick" (17.26% in crisis-involved, compared to 4.88% in non-crisis, events). These numbers suggest, not unintuitively, that greater force may be necessary to bring subjects in crisis under control.

Although a pattern of increased resistance (passive and active) is observed across force types, caution should be used when drawing conclusions from strict observation of these data, particularly when comparing unequal samples. Observed differences in force and resistance suggest crisis involved force is a distinct class of response data, but this has yet to be established empirically. Future analyses will attempt to validate this observation using appropriate methods that control for the disparate sample size; nonetheless, initial observations suggest it is the demeanor of the subject that is likely responsible for the increased occurrence of Type II force, within crisis involved interactions.

This observation is supported as well by a review of behaviors exhibited by individuals in crisis. Table 3 compares a breakdown of exhibited behaviors in crisis-involved events that involved force with those in which no force was reported.

Table 3: Distribution of Exhibited Behaviors in Crisis-Involved Events

	Involved Force		
Exhibiting Behavior	No	Yes	Total
Biologically Induced	57.67%	48.75%	57.51%
Unknown Crisis Nature	43.67%	50.54%	43.79%
Disorderly Disruptive	31.86%	74.91%	32.61%
Suicide Threat Attempt	25.77%	22.94%	25.72%
Belligerent Uncooperative	22.24%	73.12%	23.13%
Chemically Induced	22.47%	37.63%	22.73%
Neglect Self Care	14.83%	9.68%	14.74%
Unusual Fright Scared	14.31%	17.92%	14.37%
Behavior Other	8.64%	9.32%	8.65%
Medically Induced	3.93%	2.15%	3.90%
Excited Delirium	0.52%	0.72%	0.52%

As might be expected, a majority of force applications were used to bring under control subjects exhibiting "disorderly disruptive" (74.91% of force applications) and/or "belligerent uncooperative" (73.12%) behaviors, or who were engaged in a suicide attempt or threat (22.94%) – behavior that often requires immediate action to protect one's self or others.

A breakdown of injuries associated with Type I and Type II uses of force, in non-crisis and crisis-involved events, is shown in Table 4. While few notable differences are observed, a review of injuries suggests that Type II force reports involving subjects in crisis are driven predominantly by reports of abrasions and lacerations, with some observation of differences in the occurrence of soft tissue damage, bruises and the occurrence of hospital treatment. Again, however, caution should be used in drawing any conclusion from these visually apparent differences. As noted earlier, future analyses will attempt to verify Type II crisis involved force as a distinct class through appropriate statistical means[5] to handle unbalanced population size and the problem of multiple comparisons.

[5] A Principal Components Analysis (PCA) approach to Confirmatory Factor Analysis (CFA) and Bayesian classification are both valid approaches.

Table 4: Reported Injuries in Non-Crisis/Crisis-Involved Use of Force Events

	Level 1 - Use of Force				Level 2 - Use of Force				Total	
	No Crisis		Crisis		No Crisis		Crisis			
	% of Total	UoF Count	% of Total	UoF Count	% of Total	UoF Count	% of Total	UoF Count	% of Total	UoF Count
Complaint of Pain Only	53.18%	853	61.04%	199	25.46%	83	30.00%	57	48.73%	1,192
No injuries noted or visible	45.95%	737	35.89%	117	24.54%	80	17.37%	33	39.53%	967
Abrasion	1.62%	26	2.45%	8	42.94%	140	56.32%	107	11.49%	281
Laceration	0.56%	9	1.53%	5	9.20%	30	10.53%	20	2.62%	64
Soft Tissue Damage	0.19%	3	0.31%	1	4.60%	15	3.16%	6	1.02%	25
Bruise	0.37%	6			1.84%	6	2.63%	5	0.70%	17
Hospital Treated/Released	0.19%	3	0.31%	1	0.61%	2	3.16%	6	0.49%	12
EMS/At Scene			1.53%	5	0.92%	3	1.05%	2	0.41%	10
Dog Bite – Puncture	0.12%	2			2.45%	8			0.41%	10
Treatment Refused			0.31%	1	1.84%	6	1.05%	2	0.37%	9
Death	0.19%	3	0.92%	3					0.25%	6
Dog Bite – Abrasion					1.84%	6			0.25%	6
Self-Treatment					1.84%	6			0.25%	6
Hospital Admitted	0.06%	1	0.31%	1			0.53%	1	0.12%	3
EMS/At Precinct	0.12%	2					0.53%	1	0.12%	3
Sprain / Strain / Twist			0.31%	1	0.31%	1			0.08%	2
Dislocation					0.61%	2			0.08%	2
Gunshot	0.06%	1			0.31%	1			0.08%	2
Burn	0.06%	1			0.31%	1			0.08%	2
Concussion			0.31%	1					0.04%	1
Human Bite			0.31%	1					0.04%	1
-					0.31%	1			0.04%	1
Dog Bite – Rake Wound					0.31%	1			0.04%	1
Fracture					0.31%	1			0.04%	1
Grand Total	100.00%	1,604	100.00%	326	100.00%	326	100.00%	190	100.00%	2,446

While (as reported in the Department's Crisis Intervention Program Report (see Appendix A)) the overwhelming majority of crisis interactions (~ 92%) are in response to dispatched events, force occurs with greater frequency (2.78%) in on-viewed events relative to dispatched events (1.81%). While again a statistical comparison of these two populations is difficult given both the extraordinarily infrequent occurrence of force, overall, and the substantial difference in population size between dispatched and on-viewed events, some differences can be observed when comparing use of force to subject behavior in dispatched and on-viewed events.

Table 5: Exhibited Behaviors in Dispatched and On-Viewed Crisis-Involved Events

	DISPATCH		ONVIEW		
Exhibiting Behavior	Force	No Force	Force	No Force	Total
Biologically Induced	50.63%	59.18%	37.50%	50.13%	58.28%
Disorderly Disruptive	74.06%	32.19%	81.25%	36.50%	33.34%
Unknown Crisis Nature	48.54%	42.47%	62.50%	51.21%	43.29%
Belligerent Uncooperative	72.38%	22.84%	81.25%	25.29%	23.99%
Chemically Induced	36.40%	22.09%	50.00%	30.04%	23.02%
Suicide Threat Attempt	23.85%	29.35%	12.50%	12.02%	27.87%
Unusual Fright Scared	18.41%	14.08%	12.50%	15.07%	14.22%
Neglect Self Care	8.37%	15.26%	18.75%	17.67%	15.34%
Behavior Other	10.04%	8.49%	6.25%	10.76%	8.69%
Medically Induced	2.51%	3.98%		4.48%	3.99%
Excited Delirium	0.84%	0.54%		0.90%	0.57%

As shown in Table 5, on-viewed crisis-involved events involving a use of force were highly likely to involve observed subject behaviors classified as "Disorderly Disruptive," "Unknown Crisis Nature," and "Belligerent Uncooperative," and "Chemical Induced." The higher frequency of these reported behaviors in on-viewed cases, while prevalent in dispatched cases as well, suggests that officers are observing that intervening in events that, as a result of more agitated subject behavior, are more likely to result in a use of force.

In sum, initial examination of subject behaviors, officer response, and resulting injuries in crisis-involved use of force cases suggests, strongly, that crisis related use of force is a distinct type of event. While some notable differences can be observed in force classification, the observed difference is likely the result of officer response to specific subject behaviors, resulting in injuries and force applications which are definitive of the class. This is particularly true with respect to Type II uses of force, which occur with greater frequency in crisis-involved incidents than in use of force cases, overall. As noted,

future analyses will explore these apparent patterns more closely and attempt to better understand the nature of these events. Anecdotally, as discussed in Appendix A, there is discussion nationally about the rise in methamphetamine use – a category of narcotic known to cause violent and erratic behavior (see, e.g., SPD Type III case 2017-319167, discussed later in this report); these reports are consistent with data from both the Seattle Fire Department and the King County Medical Examiner that indeed show a rising trend in the number of incidents involving the use of methamphetamine. As both SPD, public health agencies, and mental health providers are able to better understand the mechanisms that drive such behavior, it is possible that additional intervention strategies may be developed that may reduce the energy of such events.

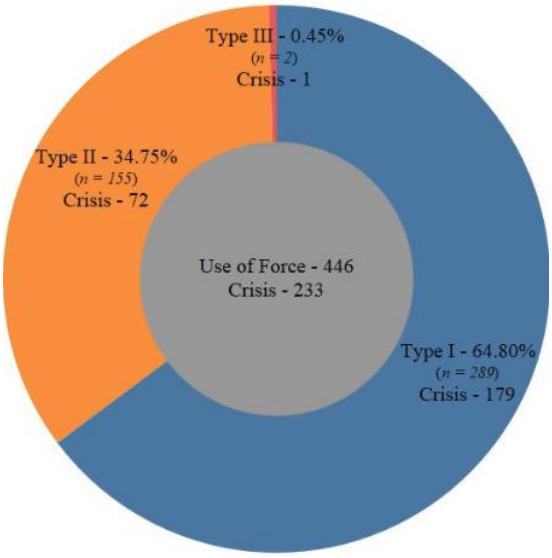
A. Qualitative Review of Type II Use of Force

As described above in Section II(B) of this report, in May 2018 the FRU (the Department's designated subject matter experts with respect to force review) began entering data from force review findings documents into a custom software application SPD developed to capture unstructured data relating to force reporting, investigation, and review. Findings for each of the Type II cases associated with a crisis template that had undergone FRU/FRB review were backfilled into this system. This application allows SPD to populate, in DAP, findings of the FRU/FRB with respect to consistency with Title 8 (Use of Force) of the Department Manual. Data reported in this section comprise both aggregated findings from this application and manual review of FIT and FRU records.

Between January 1, 2017, and June 30, 2018, FRU/FRB reviewed a total of **233** crisis-involved cases including one or more uses of force, comprising **446** separate uses of force in total. A breakdown of use of force reviewed, by type, is shown in Figure 3.[6] All Type II uses of force within this population of cases were reviewed by the full FRB.

[6] Because of the inherent time lag between the date of occurrence and the date that final review is completed, the number of cases occurring during the study period that had completed final review during that same period will be lower.

Figure 2: Distribution of Crisis-Involved Use of Force Cases Reviewed



In **three** cases (4.2%) involving a Type II use of force, the FRU/FRB referred to OPA issues relating to either the reporting, investigation, and/or use of force. **Of the allegations referred, none were sustained by OPA**. The circumstances, and OPA's findings, as to each are presented in Table 6.

Table 6: Force Review Board Referrals to OPA – Use of Force

GO Number	FRB Review	OPA Determination
17-470105	West Precinct officers were dispatched to a male in crisis who was talking to himself and waiving a steak knife in the air. When officers arrived, the subject had fled on foot and was not located. A short time later, East Precinct officers were dispatched regarding the same subject, who was again talking to himself, while waiving a knife in the air. The East Precinct officers located the male and approached him in their patrol vehicle. The subject put his hands in his pockets, walked towards the patrol car, then suddenly ran past the officers and down the street. Officers exited their patrol vehicle and followed the subject on foot. Officer A caught up to the subject and pushed him from behind, knocking him to the ground. When the subject fell, a knife was dislodged from the subject and fell to the ground. Officer A fell on top of the subject and attempted to gain control of his arms. Officer A and Officer B both gave the subject verbal commands, while attempting to physically restrain him. The subject continued to resist arrest and kept moving his hands towards his waist, where officers believed he had access to weapons. Each officer, believing the subject posed a threat to their safety, deployed their	OPA reviewed six allegations in total (three relating to each Named Employee (NE) relating to de-escalation, the use of the Taser specifically, and the authorization for use of force. As to all allegations, OPA issued findings of **"Not Sustained – Lawful and Proper."**

	Tasers separately at the subject. The first Taser deployment was unsuccessful (both probes did not make contact). After the first deployment, the second officer deployed his Taser with a drive stun application. The second Taser application was successful, allowing the two officers to gain control of the subject's arms and apply handcuffs. The FRB identified as a training issue that the officers did not fully describe their actions and decision-making with respect to training concerning using time, distance, and shielding absent the need to take immediate action. Based on this deficiency in documentation, the FRB could not determine whether the officers took reasonable steps to de-escalate prior to using force, and referred the matter to OPA.	
18-098491	Anti-Crime Team officers located a felony warrant subject walking into a local strip mall store and requested patrol officers to assist with his apprehension. The subject was known to run from officers upon contact and was considered dangerous due to previously firearms convictions. The backing officers arrived in the area and were directed by ACT officers to the subject. They made verbal contact with the subject who responded by fleeing on foot. As the officers followed on foot, the subject realized he was trapped and gave himself up by lowering himself to a seated position between two parked vehicles. Officers approached the subject and immediately applied control holds, transitioning him to a prone handcuffing position on the ground. When the officers began to position the subject's arms behind his back, the subject pulled his left arm away from them. The subject then attempted to push himself up off the ground with his left arm. The officers retained control of the left arm and placed both the subject's wrists into handcuffs. When officers began to escort the subject to a patrol vehicle, he actively resisted, and yelled/cursed at one officer. The subject dropped his body weight and laid on the ground. The officers determined they would carry the subject to the patrol vehicle, so four officers lifted him off the ground. While carrying the subject to the patrol vehicle, he made a complaint of pain that the officers broke his wrist. The FRB reviewed three separate uses of force - Type II force on the initial contact, and Type I contact post-contact. The FRB found that officers acted consistent with de-escalation tactics and training with regard to the initial contact (finding specifically that de-escalation was not safe or feasible), but found that officers did not appropriately seek to de-escalate post-contact, noting that, when the subject dropped his body weight, there was no exigency, and that officers could have taken a moment to reassess	OPA reviewed a total of 17 allegations against four officers relating to de-escalation, use of force authorization, use of force prohibitions, and professionalism. As to all allegations relating to de-escalation, OPA issued findings of **"Not Sustained – Lawful and Proper."** As to all allegations relating to use of force authorization, OPA issued findings of **"Not Sustained – Lawful and Proper."** As to all allegations relating to use of force prohibition, OPA issued findings of **"Not Sustained – Unfounded."** As to all allegations relating to professionalism, OPA issued findings of **"Not Sustained – Unfounded."**

	the situation and modulate their force, rather than using an untrained technique (picking up the subject). The FRB referred this issue to OPA. At the time of the FRB review, OPA was reviewing allegations concerning the Type II force that had been forwarded by FRU. The FRB accordingly deferred its findings to OPA.	
18-101563	Officers were dispatched to assist AMR personnel at the Crisis Solutions Center, where a patient threatened to kill responders and damaged a wall. The officers arrived on-scene and located the subject still arguing with staff members and AMR personnel. The officers announced their presence and identified themselves to the subject. They attempted to achieve cooperation from the subject by explaining the situation and options for a resolution. When the subject refused to cooperate, the officers determined the subject was in crisis and would be involuntarily committed. AMR personnel attempted to place the subject into soft restraints but he began to resist them. The officers stepped in to assist by holding the subject's arms, legs, and wrists so that he could be placed into soft restraints. While officers were restraining the subject's right arm, he yelled out that an officer broke his wrist. The officer repositioned his hold on the subject's arm and continued to hold him until the soft restraints were applied. The officers notified their sergeant of the situation and requested he come to the scene. AMR personnel evaluated the subject for injuries and noted he complained about his left wrist being injured not his right wrist, as he had initially claimed. During the interview with the investigating sergeant, the subject recanted his story and claimed he was not injured. The subject was transported to HMC via AMR for a mental evaluation. (Note: this case was screened by FIT, which concurred in the Type II investigation.) The FRB found the officers' efforts to de-escalate, and the force used, to be consistent with policy. However, in light of the subject's complaints, in an abundance of caution and after consultation with the OPA Director, the complaint of force was submitted to OPA for review.	OPA noted that the incident had been screened with FIT, which had declined to respond after it was determined that the subject had no injuries and this was only a complaint of pain. OPA concluded that the contact in question was captured by video and that the involved employee's action to not appear to support the claim of assault or excessive force. OPA determined, however, that in light of the subject's comment "You just broke my wrist. It snapped. This is an assault[,]" the chain should have referred the allegation to OPA. OPA issued a **supervisor action notice** requesting roll call training to remind officers and supervisors to report alleged force, rather than just consulting FIT.

In **one** case, the FRB found the officers' actions to be consistent with use of force policy and training, but referred to OPA allegations concerning separate possible policy violations. **OPA returned this case for supervisor action.** This case is described in Table 7.

Table 7: Force Review Board Referrals to OPA - Other

GO Number	FRB Review	OPA Determination
17-069129	Officers A and B were patrolling on bikes when they on-viewed a subject camping on city property. Officers contacted the subject and requested identification. The subject refused to provide identification to officers. The officers believed he was trying to conceal his identity in order to hide a possible warrant. The officers called for a Mobile Fingerprint ID Device to be brought to the scene. While waiting for the Mobile ID to be delivered, the subject stood up to stretch, then fled on foot from officers. Officer A chased after the subject. He was able to catch up to the subject and grab him from behind. The momentum of grabbing the subject while running knocked both the subject and Officer A to the ground. Officer C arrived and assisted Officer A. Both Officer A and Officer C tried to control the subject's upper body. Officer B arrived and held down the subject's legs. The subject was able to retract his leg and kick Officer B in the knee. In response to the subject's assaultive behavior, after hearing that Officer B had been assaulted, Officer C provided a closed punch strike to the subject's face in an attempt to stop the assault on Officer B. The struggled continued until officers were able to successfully apply handcuffs and take the subject into custody. The FRB made OPA referrals concerning the use of the mobile Fingerprint ID device (Manual Sections 15.360 and 6.220) and detainee management, regarding officers' decision to process into evidence only the subject's backpack, rather than materials associated with the subject's tent.	OPA referred the case back to the chain for a **supervisor action**, requesting that the chain review with the named employee (1) Manual Section 15.360 concerning the Mobile Fingerprint Device and circumstances in which it can be used; and (2) the need to document that if property belonging to an arrested person is left in place, to make note of that in the GO report to avoid concerns regarding property disposition.

In **nine** cases (12.5%), OPA complaints, generated either by the Chain of Command (two cases) or a third-party (either individually or as forwarded by the Chain of Command) were pending at the time of the FRB review. Accordingly, FRB discussed tactics and decision-making around the use of force, but deferred findings to OPA. **Of these eight cases, each containing multiple allegations, OPA sustained allegations relating to the force itself in only one.** These cases are described in Table 8.

Table 8: FRB Cases with OPA Review Pending

GO Number	FRB Review	OPA Determination
17-078011	A resident called 911 to report a burglary in progress in the shed that was attached to the back of her house. The caller advised the suspect was still inside. Multiple officers were dispatched and immediately began setting up containment. One officer updated radio that he could see the suspect standing in the victim's backyard. The suspect suddenly ran down the driveway towards Officer A, where he had set up his containment position. Officer A drew his duty weapon, pointed it at the suspect, and ordered him to get on the ground. The suspect refused Officer A's commands and continued to flee. Officer B and C observed the fleeing suspect and gave chase. They caught up to the suspect and were able to grab hold of him. The suspect began flailing his arms in an attempt to escape their grasp. Officers B and C used a team takedown to get the suspect on the ground to control his movements. While on the ground, officers observed the butt of a firearm in the suspect's waistband. Officers B and C used control holds to keep the suspect pinned to the ground until Officer A arrived to assist with handcuffing. Officers recovered two suspected firearms from the suspect's waistband after he was in custody. The FRB found the officers' actions consistent with de-escalation policy and found Officer A's pointing of a firearm to be reasonable, necessary, and proportional. At the time of the FRB review, OPA was investigating a complaint by the subject that Officers B and C had used excessive force; FRB, accordingly, deferred to OPA's findings.	As to NE #1, OPA determined the allegation to be **"Not Sustained – Lawful and Proper."** As to NE #2, OPA issued a finding of **"Not Sustained – Inconclusive"** based on what OPA determined to be inconsistencies in NE #2's statements as to whether the takedown and control hold involved the head, the face, and/or the neck.
17-185652	Officers were dispatched to an assault call where an unknown female punched the victim in the face. Officers located the suspect based on a description provided by the victim. Following a positive identification, the suspect was taken into custody for assault. While being placed under arrest, the subject yelled and screamed at officers. The subject escalated by spitting on Officer A's face. Officer A forced the suspect's head down onto the hood of the patrol car to prevent her from spitting on officers. A spit sock was placed on the subject's head for transport and to prevent further spitting. Due to the subject's behavior, she was transported to the precinct for processing the use of force and arrest was subsequently screened at the precinct. At the time of the FRB review, allegations concerning de-escalation and the use of force were under OPA review. Additional issues identified by the FRB included deficiencies in documentation (subsumed in the initial referral), to include lack of specific information concerning	As to three allegations concerning force reporting and investigation by NE #1, OPA issued, **"Not Sustained – Inconclusive," "Sustained", and "Not Sustained – Training Referrals".** As to the same three allegations concerning NE #2, OPA issued **"Not Sustained – Training Referrals**" on each. As to two allegations concerning standards and duties involving NE #3, OPA issued a **"Not Sustained – Inconclusive**" on one and **Sustained** the second. As to two separate force reporting allegations involving NE #3, OPA **sustained** one allegation and issued a **"Not Sustained – Training Referral**" as to the second. OPA **sustained** three

GO Number	FRB Review	OPA Determination
	that the force (placing her head on the car to prevent spitting) involved a handcuffed subject, photographs of the subject, and information as to whether the subject was closely monitored while wearing the spit sock. The FRB also noted that officers could have called ARM for a transport, rather than using the patrol vehicle (Note: this option is no longer available.)	allegations relating to the force itself. OPA dismissed a complaint concerning the application of the spit sock as **"Not Sustained – Lawful and Proper."** As to NE #4, OPA **sustained** an allegation concerning duties and responsibilities and issued **"Not Sustained – Training Referral"** and **"Not Sustained – Lawful and Proper"** findings as to two allegations concerning force reporting and investigation.
17-269114	Officer A was working to address exclusionary zone violations that were occurring on an Aurora Avenue off-ramp at Denny way after he noticed clothing and luggage next to the roadway. He removed the items and was preparing to leave when he was approached by the subject, who said that the was the owner of the items. Officer A attempted to explain why he removed the items, and the subject became upset. Officer A requested an additional officer to respond. Once the additional officer arrived, the subject refused to leave the roadway, causing a hazard for traffic and established probable cause for pedestrian interference. The subject was advised that he was under arrest after he refused to move out of the street. When officers went to take the subject into custody, he resisted their efforts. The officers took the subject to the ground, causing a scrape to his elbow. The subject then broke free and attempted to jump over a barrier onto a lower part of the roadway. The officers were able to stop the subject, overcome his resistance, and place him into a patrol vehicle. Later, after being placed in a holding cell, the subject was viewed on video banging his head into the walls, causing a laceration. He was treated by SFD and transported to HMC via AMR. At the time of the FRB review, OPA was reviewing several complaints by community members who had witnessed the interaction, as well as complaints by the subject who complained that he was subjected to excessive force, unlawfully arrested, harassed, and treated unfairly due to his housing and economic status.	In total, OPA reviewed seven complaints concerning the use of force, de-escalation, bias-free policing, standards and duties (professionalism) and standards and duties – use of discretion. The OPA Director issued **"Not Sustained"** findings as to all; allegations concerning the use of force, de-escalation, and the arrest were found to be **"Lawful and Proper;"** allegations concerning bias were found to be **"Unfounded;"** and one allegation concerning the use of discretion was not sustained as **"Inconclusive."**
17-360655	**As every aspect of this case was taken under investigation by OPA based on a referral from the Downtown Emergency Services Center (DESC), the FRB deferred to OPA in full.** The following summary is taken from the OPA Director's Certification Memo: It was alleged that Named Employee #1 engaged in a number of policy violations during a physical altercation with the subject in a DESC building, including the use of excessive force and the failure to de-escalate. Named Employee #2, Named Employee #3, and Named Employee #4 were alleged	

GO Number	FRB Review	OPA Determination
	to have potentially failed to report an allegation of serious misconduct and to have generated incorrect and incomplete paperwork. It was alleged that Named Employee #5 engaged in policy violations during his review of the force used and that Named Employee #6 violated policy during his classification and investigation of the force and by purportedly failing to investigate or refer an allegation of serious misconduct. Lastly, Named Employee #7 was also alleged to have failed to have reported an allegation of serious misconduct. On the date in question, Named Employee #1 (NE#1), Named Employee #2 (NE#2), Named Employee #3 (NE#3), and Named Employee #4 (NE#4) responded to a call for service at a DESC building. The call was regarding the subject, who was alleged to have attempted to assault a DESC employee and was refusing to leave the building. I note that the entirety of the officers' response to this call was captured by Body Worn Video (BWV) and video cameras located at DESC. The responding Named Employees observed an individual lying on the floor of the DESC lobby, who was identified as the subject. The officers made contact with DESC employees, who told them that the subject threw a punch in the direction of a staff member but that it did not make contact. The DESC employees said that the subject then got onto the ground and would not leave when asked to do so. They told the officers that if the subject did not leave the vicinity, they wanted him to be trespassed. After speaking with the DESC employees, the officers moved into the lobby and made contact with the subject. They called the subject's name and identified themselves as police officers. The officers told the subject that he needed to leave the building. NE#3 shined a flashlight on the top of the subject's body and then she and NE#4 began to tap his feet to get him to wake up. NE#1 shook the subject's shoulder. The subject told the officers to "get the fuck off of me" repeatedly. NE#1 told him that he should not talk to her like that. The officers, who were surrounding the subject, took a few steps back as the subject began to move around and continued to tell him to get up and leave the building. The subject stood up and again told the officers to "get the fuck off of me." The subject took a step towards NE#1, pointed his finger in her face, and said "don't you fucking come near me." NE#1 pushed him back towards the wall with a straight hand and told him "do you want to do that?" The other officers converged on the subject. At that point, NE#1 claimed that the subject struck at her with his left hand and, when he did so, she "ducked" her head back and down. She stated, however, that the subject still hit her cheek with his hand. NE#1 reported that she did not know whether he struck her with an open hand or a closed fist. She further stated that he kicked his leg out at her. While explaining why she used force to OPA, NE#1 again stated that she was "assaulted" by the subject. In his use of force report, NE#2 stated that, after the subject stood up and began to interact with NE#1, he saw NE#1 "abruptly move her head," suggesting that she was either struck or that she had dodged an attempted assault. NE#2 did not report observing the subject make contact with NE#1. He remained consistent with this account at this OPA interview. NE#2 told OPA that he observed NE#1's head move back as if she had been struck or was avoiding being struck but that he could not see exactly what happened given his positioning. He recalled that, after the incident occurred, NE#1 pointed to her mouth and asked whether she had any marks on her face. In her use of force report, NE#3 reported seeing the subject "strike [NE#1] on the face and continue to move towards her." She reaffirmed at her OPA interview that she saw the subject strike NE#1. NE#4 reported that he observed that the subject "reached up and pushed" NE#1. He did not note seeing a strike to NE#1's face in his use of force report. However, at his OPA interview, NE#4 said the following: "And then he just immediately, very quickly, just punches her or goes to punch her and fortunately she was able to defend herself." As discussed below, appears to be inconsistent with his use of force statement.	

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	While NE#1's BWV captured her initiation of the interaction with the subject and her first push to his body, it does not clearly show whether or not the subject struck her as she and NE#3 claimed. NE#2 was not equipped with BWV on that day. NE#3's BWV did not, from my review, clearly show what occurred. NE#4's BWV provided a fairly clear view of much of the lead up to the force. There was a moment where the right side of the subject's body was not captured by the video and a noise was made that could suggest contact. (*See* NE#4's BWV, at 6:45-6:46.) However, NE#4's BWV does not conclusively show the subject ever striking or making physical contact with NE#1's face. The altercation was also captured by DESC video. On this video, NE#1 and the subject can only partially be seen. Notably, the subject's right side and NE#1's left side are outside of the view of the camera. The video did show, however, apparent movement by the subject from his right side, which could be consistent with his striking at NE#1. It also showed NE#1 moving backwards immediately after the subject's apparent movement. When she moved backwards, the entirety of her body was within the view of the camera. It is possible that in the second between the apparent movement by the subject and NE#1 moving into full view of the camera, her face was struck. (*See* DESC Video #1, at 1:55-1:56.) That being said, it is unclear from a review of the video whether that did, in fact, occur. NE#1 then engaged in a physical altercation with the subject. From my review of the BWV, she punched him approximately six times and kneed him at least twice. This is consistent with the force that NE#1, herself, reported. NE#2, NE#3, and NE#4 grabbed onto the subject's arms and body and assisted NE#1 in taking him to the ground. As discussed more fully below, NE#1's force was clearly Type II. I agree that the other Named Employees likely only used de minimis force during the takedown. From my review of BWV and DESC video, no further force was used against the subject when he was on the ground. He was handcuffed and the Seattle Fire Department (SFD) came to treat his injuries. He was bleeding from his mouth and nose areas, but apparently suffered no other significant physical harm. The subject continued to be uncooperative and would not let SFD personnel medically treat him. After the force occurred and while the subject was secured on the ground, Named Employee #6 (NE#6) – the officers' sergeant, Named Employee #7 (NE#7), and another officer and acting sergeant arrived on the scene. NE#6 directed a Type II use of force investigation and the steps he took in that regard were detailed on BWV. The investigation and related documentation were reviewed by the officers' chain of command, including Named Employee #5 (NE#5). Approximately six days after the incident, DESC staff members initiated an OPA complaint regarding this matter. The DESC staff were particularly concerned with the actions of NE#1, which they believed constituted excessive force and the failure to de-escalate. During his review, NE#5 also referred to OPA the potential failure of several of the Named Employees to report an allegation of misconduct made by a witness. As to two allegations against NE #1 concerning use of force, OPA issued findings of **"Not Sustained – Inconclusive"** as to one, and **"Not Sustained – Unfounded"** as to the other. As to allegations concerning de-escalation against NE #1, OPA issued a finding of **"Not Sustained – Lawful and Proper."** As to two additional allegations concerning standards and duties (professionalism and discretion), OPA issued findings of **"Not Sustained – Inconclusive."** As to one allegation against NE #2 concerning reporting of alleged policy violations, OPA issued a finding of **"Not Sustained – Unfounded."** As to three additional allegations concerning use of force investigation and reporting, OPA issued findings of **"Not Sustained – Lawful and Proper."**	

GO Number	FRB Review	OPA Determination
	OPA **sustained** one allegation against NE #2 concerning the reporting of certain policy violations. As to two additional allegations concerning use of force investigation and reporting, OPA issued findings of **"Not Sustained – Lawful and Proper."** As to one allegation against NE #4 concerning the reporting of policy violations, OPA issued a finding of **"Not Sustained – Unfounded."** As to three additional allegations concerning use of force investigation and reporting, OPA issued findings of **"Not Sustained – Lawful and Proper."** As to two allegations against NE #5 concerning use of force investigation and reporting, OPA issued findings of **"Not Sustained – Lawful and Proper."** As to one allegation against NE #6 concerning the reporting of policy violations, OPA issued a finding of **"Not Sustained – Unfounded."** As to an additional allegation concerning use of force investigation and reporting, OPA issued a finding of **"Not Sustained – Lawful and Proper."** OPA **sustained** one allegation against NE #7 concerning the reporting of policy violations.	
17-417824	While SPD officers were at the scene of a traffic accident involving a vehicle and a pedestrian that resulted in a fatality, an individual (the subject, and the complainant in the OPA matter) called 911 to say that officers had shot someone. Based on the call, a subsequent call, and the subject's rambling and incoherent speech during those calls, the 911 operator identified that the subject/complainant was possibly in crisis. Shortly thereafter, A/Sgt. A, who was at the scene of the collision, was flagged down by a citizen regarding a person on the ground who appeared to be having a medical emergency (acute alcohol poisoning or substance overdose). As the sergeant went to the scene, he noticed a man down, with the subject/complainant kneeling next to him. While the sergeant assessed the situation, the subject began to interfere. The sergeant asked the subject to back away from the person on the ground several times. When the subject refused, the sergeant requested another unit to his location. As backing Officer A arrived, the subject became increasingly hostile and continued to interfere with officers' efforts to assist the person on the ground. The subject was informed that he was under arrest, and Sgt. A took hold of his elbow to take him into custody. As the sergeant attempted to bend the subject's arm into a position to be handcuffed, the subject suddenly struck the sergeant in the chest with his elbow. Officer A ran over and was able to assist as they struggled with the subject on the ground until additional officers arrived. The additional officers were able to control the subject until he was placed into handcuffs.	OPA reviewed a total of seven allegations against three named employees, one concerning the failure to activate in-car video, and the remaining relating to de-escalation, use of force, and reporting and investigation of force. OPA **sustained** the allegation relating to ICV. As to the remaining six, OPA issued findings of either **"Not Sustained – Unfounded"** or **"Not Sustained – Lawful and Proper."**

GO Number	FRB Review	OPA Determination
	At the time of the FRB review, OPA was reviewing a complaint of excessive force that the chain of command referred after receiving the subject's complaint. The FRB noted that the chain of command separately and appropriately identified, and addressed, issues concerning the sergeant's de-brief (together, rather than individually) with the involved officers, and noted that although it was documented that a spit sock was applied, the reason for the application was not articulated in the officers' reports.	
17-424093	Officers were dispatched to a residence after the tenant called to report his friend, a guest at the residence, was threatening to kill himself. Officers spoke with the caller who informed them that the subject had cut his wrist with a razor blade and went into the bathroom. The tenant let the officers into the apartment and directed them to the bathroom, where the subject was hiding. Officers attempted to make verbal contact with the subject through the closed door, but received no response. Officers decided to enter the bathroom to get a better assessment of the situation. They developed a tactical plan and designated roles that included a Taser officer, lethal cover, and an arrest team. Officers opened the bathroom door and observed the subject cutting himself with the razor blade. Th subject looked at the officers and retreated into the shower tall. Officers ordered the subject to drop the razor and he complied. After dropping the razor, the subject continued to try and injure himself by clawing at the self-inflicted lacerations on his wrist and forearm. Officers attempted to verbally de-escalate the subject, who had clenched his fists. When this failed, the Taser officer gave an arc warning on his Taser as a de-escalation technique to discourage the subject from attacking them. The subject responded to the arc warning by closing the shower curtain. When officers pulled open the shower curtain, the subject appeared ready to fight. The subject's fists were clenched, muscles tensed, and he appeared as if he was going to charge at the officers. The Taser officers believed the subject was going to attack, and in response to the threat, he deployed his Taser. The Taser deployment was effective, causing neuromuscular incapacitation. Officers entered the small bathroom and prevented further injury to the subject by using a team takedown to restrain the subject on the bathroom floor where he was placed into custody. The subject was transported to HMC for his self-inflicted injuries and for an involuntary mental health evaluation.	This case involved an OPA-initiated complaint containing allegations concerning the use of ICV, use of force, and de-escalation. Noting that the NE did activate body-worn video, OPA issued a **"Not Sustained – Training Referral"** finding, and submitted to the Department a Management Action requesting that the Department clarify the language of Manual Section 16-090-POL-5 "to make clear that where officers are equipped with both ICV and BWV, it is the intent of the policy that they will record on both systems. The Department should further clarify that simply recording on one and failing to record on the other is improper when the secondary system is required to be activated under this policy." As to allegations concerning de-escalation, the authorization to use of force, and the use of force against NE #1 (the Taser officer), OPA issued a finding of **"Not Sustained – Lawful and Proper"** as to the first, **"Not Sustained – Training Referral"** as to the second, and a finding of **"Not Sustained – Management Action"** as to the third, requesting that the Department "amplify its Taser training to provide clearer guidance as to what constitutes an imminent risk of harm justifying the use of a Taser; and more explicit explanations of what constitutes

GO Number	FRB Review	OPA Determination
	The FRB noted that the chain appropriately handled training issues around (1) although the officers called a sergeant to the scene as soon as feasible, a sergeant had not initially been dispatched to the call; (2) that the officers did not treat the subject, initially, as a barricaded subject; and (3) that the FTO at the scene did not recognize that his student officer was too close to the subject in the bathroom, thus placing himself at risk.	the 'public safety interests' that are referenced in the policy and what conduct is sufficient to meet the requisite 'level of resistance' from the subject."
18-004914	An officer initiated a traffic stop on a vehicle in a parking lot where several pedestrians (not associated with the traffic stop) were located. As the officer began to exit his vehicle, one of the pedestrians charged towards the officer yelling, "Get out of here, go back where you came from." The subject had clenched fists and began striking them on the officer's patrol car. The officer remained inside his car, closed the door, locked it, and watched as the subject verbally threatened him from outside the car. When the subject stepped away, the officer made an attempt to get out of the car again. The subject again approached him in a threatening manner, at which time the officer retreated into his vehicle again and requested backup. After backing officers arrived, the involved officer used a control-hold takedown of the subject and placed him under arrest. After being transported to the precinct the subject complained of broken ribs. SFD responded and cleared the subject of injury; he was then transported to King County Jail for booking. The FRB identified as training issues retreating to his vehicle and remaining at the scene – training standards would have been to take immediate action and contact the subject or create space by moving the vehicle, which would have been safer. The FRB also noted that the officer did not either terminate the traffic stop or advise the vehicle driver that he was free to leave, thus leaving him at potential risk of harm by the subject. The FRB noted that the chain of command appropriately addressed this issue. At the time of the FRB review, OPA was reviewing the use of force following a chain of command submission of a third-party (a witness who observed part of the incident) complaint to OPA.	OPA reviewed two complaints against one named employee relating to de-escalation and the use of force. As to both, OPA issued findings of **"Not Sustained – Lawful and Proper."**
18-017258	Officers were dispatched to investigate a trespass call at a residence, where two Airbnb guests were in a dispute. Officers arrived and located the female subject who was causing a disturbance. Officers attempted to speak with the subject, but she refused to cooperate. As the subject attempted to leave, the officers advised her that she would be placed in handcuffs if she attempted to leave before the investigation was complete. The subject began to argue	OPA reviewed 5 allegations against NE #1 and NE#2, each, three relating to stops and detentions (limit in scope, subject identification, and based on reasonable suspicion); one relating to arrest (probable cause); and one relating to the use of force. For

GO Number	FRB Review	OPA Determination
	with the officers, stating that she had done nothing wrong. Officers believed they had probable cause to arrest the female subject for trespassing and attempted to place her in handcuffs. The subject resisted arrest by pulling her arms back and refusing to cooperate with their commands. During the struggle, the subject pushed one of the officers, causing him to fall to the ground. While falling to the ground, the officer pulled the subject to the ground with him. Both officers struggled with the subject on the ground until they were able to place her into handcuffs. The subject was transported to the precinct where she complained of pain to her face. SFD responded to treat the subject for possible injuries. The subject was cleared of any injuries and transported to KCJ. Prior to the FRB review, the Chain of Command had initiated an OPA referral after identifying concerns with the decision to arrest, to initiate the stop, de-escalation and the use of force; the FRB concurred with these referrals.	both employees, as to the allegations concerning the stop, OPA issued findings of **"Not Sustained – Training Referral", "Sustained,"** and **"Not Sustained – Lawful and Proper,"** respectively. As to the allegation concerning the arrest, OPA issued a finding of **"Sustained."** As to the allegation concerning the use of force, OPA issued a finding of **"Not Sustained – Training Referral."** OPA separately reviewed an allegation concerning the sergeant's screening and approval of the arrest, issuing a finding of **"Not Sustained – Training Referral."**
18-130285	Multiple officers responded to a hit and run accident where witnesses reported the driver was intoxicated and had fled the scene on foot. While officers were responding to the scene, witnesses updated radio as to where the subject was hiding. When officers arrived on-scene, they located the subject in a fenced courtyard of a residence. The owner of the residence unlocked the gate and let the officers onto their property so they could remove the subject. The officers contacted the subject who refused to comply with their orders. The officers formulated a plan, approached the subject as a team, and lowered her to the ground when she started to resist. Once the subject was handcuffed, she refused to stand up and walk on her own. Two officers carried the subject up a small stairwell leading to the sidewalk, where the patrol vehicles were parked. At the top of the stairs the subject agreed to stand up and walk on her own, so the officers placed her legs back on the ground. When the officers escorted the subject to the front of a patrol vehicle, she violently kicked the front bumper. In response, the two escorting officers leaned the subject over the hood of the car to prevent her from further damaging or injuring herself by kicking the patrol vehicle. The subject then struck her head on the hood of the patrol vehicle. To prevent her from further injuring herself, officers moved the subject to an adjacent grass planting strip and lowered her to the ground. The officers retrained the subject on the ground as she attempted to kick them and thrashed about. While on the ground, the subject made several complaints of pain and accused the officers of hurting her. Officers called AMR to transport her to the hospital for a blood draw related to the collision. While	OPA reviewed allegations against three named employees (two officers and one sergeant) and an unidentified/unknown officer. The complainant's allegations, and OPA determinations, are as follows: (1) That NE #1 subjected her to excessive force while she was restrained on a hospital gurney by bruising her wrist when he attempted to remove an object from her hand. Noting that the subject had made statements of self harm, was holding a metal object in her hand that could be used for self-harm, and refused to release it, OPA issued a finding of **"Not Sustained – Lawful and Proper."** (2) That the on-scene sergeant was "a dick" and engaged in excessive force when a different officer injured her elbow. OPA issued **"Not Sustained – Unfounded"** findings as to these allegations based on the fact that the video, which shows the incident in its entirety, establishes no contact. (3) OPA also reviewed allegations that the sergeant failed to assist the complainant in filing a report by not asking her whether she wanted to file a report, and

GO Number	FRB Review	OPA Determination
	being interviewed by the investigating sergeant, the subject attributed bruising on her right bicep to A/Lt. A, who was not present when she was taken into custody. While the subject was at the hospital, the officer assigned to hospital guard noticed that she had a necklace with a key similar to a handcuff key around her neck. The officer called hospital security to assist him in removing the necklace/key due to the subject's violent behavior. The subject later claimed the officer hurt her when he removed the necklace. The subject was released from the hospital after the blood draw and then booked into KCJ. The FRB found the officers' efforts at de-escalation to be consistent with policy and training, and approved five of the six officers' use as reasonable, necessary, and proportional. Prior to FRB review, the Chain of Command had forwarded, on behalf of the complaining subject, the subject's complaints about the force used by the officer on hospital guard and the allegations about professionalism and use of force by a. on-scene sergeant. FRB accordingly deferred its findings to OPA's review.	failed to report her complaints of pain. OPA issued **"Not Sustained – Lawful and Proper"** as to the former, and **"Not Sustained – Training Referral"** as to the latter. (4) OPA reviewed allegations that that an unknown employee used excessive force against her. Again, based on video review, OPA issued a finding of **"Not Sustained – Unfounded"** as to this allegation.

In **one** case, OPA received a complaint from the subject via the Chain of Command prior to FRB review; because OPA determined not to investigate, the matter was reviewed by the FRB. See Table 9.

Table 9: FRB Review Following OPA Return

GO Number	FRB Review	OPA Determination
18-126821	ARM employees flagged down Officer A to report they observed a male subject assaulting a female at a bus stop. Officer A detained the male subject, who was nearby. The subject admitted to Officer A that he had his hands on the woman and that he didn't know her. The subject also expressed his intentions were sexually motivated and he didn't care if the woman consented to his advances or not, because he wanted to have sex with her. A female backing officer, Officer B, arrived on-scene and Officer A explained the situation. Officer A requested that Officer B watch the subject while he spoke to the female subject to get her account. After Officer A walked off, the subject stood up, ignoring orders to stay seated, and grabbed ahold of Officer B's hand and then attempted to grab her genitalia. Officer B radioed that she needed Officer A to return to assist with	The subject made a complaint of excessive force that was forwarded by the Chain of Command to OPA. The OPA Director specified that this was an expedited case, would not be sustained, and the involved employees would not be interviewed.

	the subject. He returned and the two officers attempted to handcuff the subject, who became physically resistant. The subject continued to resist arrest and pulled way from the officers. The officers placed the subject on the ground in a prone position and then into handcuffs. Post-arrest, the subject complained of pain to his head and knee. SFD responded, evaluated, and cleared him medically. The subject was transported to KCJ where a small abrasion was located on his left forearm. The FRB found that the officers took reasonable steps to de-escalate and that the force was reasonable, necessary and proportional. The FRB noted as training issues that the officers should have been more aware of officer safety issues, as they separated without having frisked the subject or securing him in handcuffs. The FRB recommended that this case be referred to Training for incorporation into future training sessions on tactics. Prior to FRB review, the Chain of Command had forwarded to OPA the subject's complaint that the officers had used excessive force. For the reasons stated in the adjacent column, the FRB did not defer its findings on the force.	

Finally, in **two** cases, the FRB noted concerns about tactics and decision-making and on-scene supervision, but noted that all concerns had been addressed prior to its review by the Chain of Command. See Table 10.

Table 10: Issues Addressed by Chain of Command Prior to FRB Review

GO Number	FRB Review
18-020083	Officers responded to a call of a male throwing items at passing vehicles. When officers arrived in the area, they located the subject who had disrobed and was running around in the street. When officers contacted the subject, he ran from them. Officers followed the subject on foot until he jumped into a trashcan and refused to come out. A supervisor, CRT units, and additional resources were called to the scene. Officers negotiated with the subject for the next 40 minutes. When the subject began lunging from the trash can and striking a parking sign, the Taser officer deployed his Taser at the subject. The Taser deployment was ineffective. The Taser officer then accidentally deployed a second set of probes into the ground. The Taser officer attempted to re-energize the probes on the subject twice, which was also ineffective. Officers continued to negotiate with the subject for the next 20 minutes. When the subject began to spit on officers, they moved in, restrained the subject, and removed him from the trash can. When officers attempted to place the subject on a gurney for transport to the hospital, he began to resist them again. The supervisor used a compliance technique to gain control of the subject. The subject was then transported to HMC for evaluation and then booked into KCJ. The FRB found that the officers took reasonable efforts to de-escalate prior to using force, and found that the force used was reasonable, necessary, and proportional. The FRB expressed concerns, however, with the tactics and decision-making employed by the on-scene supervisor,

	concluding that the supervisor did not formulate or articulate a clear plan to officers on-scene. The FRB further noted that these issues had been identified, and addressed, by the Chain of Command prior to FRB review.
18-027032	Officers were dispatched to a local gas station where a male was reported walking through a parking lot with a hammer in his back pocket and looking into parked cars. The caller also reported that the subject was associated with a dark SUV. When the officers arrived, they located a dark Ford Explorer SUV with the subject sitting in it. The officers recognized the subject from pervious contacts, but since no crime had been committed, the officers cleared the scene. At a nearby location, an officer performed a records check on the subject and located a felony DOC warrant. When the officers re-contacted the subject, they placed a patrol car in front of the subject's SUV, blocking his escape route. The officers gave the subject orders to exit his vehicle and informed him that he had a felony DOC escape warrant for his arrest. The officers attempted to establish a dialogue with the subject, using a clam tone and using his name to personalize the contact. The subject locked the vehicle's doors and refused to come out. The subject appeared to be under the influence, was possibly armed with a hammer, and was talking incoherently. An officer safety caution was associated with the subject. One officer found the rear hatch of the vehicle unlocked and unlocked all the vehicle's doors using the rear vehicle power lock switch. The officers opened the driver's side door and pulled the subject from the vehicle with minimal effort. The officers used a team takedown to place the subject on the ground while giving commands for him to get down and to stop resisting. After taking the subject to the ground, the officers placed him into handcuffs without further incident. The subject was treated at the scene by SFD for minor abrasions and was booked into KCJ. The FRB found the officers used de-escalation tactics and force consistent with policy. The FRB cited three issues with the on-scene supervision, however, in that (1) the sergeant deferred the photographs of the subject to an officer, rather than taking them himself; (2) the FRB discussed as an "excited utterance" the subject's comment that the officers were "racist ass bitches" and noted that no bias review was initiated, but ultimately agreed that no bias review was possible because the subject was unable to focus or answer questions; and (3) noted an FRU complaint to OPA (subsequently initiated as a Frontline Investigation) regarding the sergeant's failure to Mirandize the subject as he was arrested for a warrant. The FRB noted, however, that all issues had been identified and addressed by the Chain or FRU.

B. Qualitative Review of Type III Use of Force

In addition to full FRB review, two Type III cases were reviewed by OPA - one by way of a third-party complaint (2017-319167), and one by way of an FRB referral. In both, OPA issued "not sustained" findings as to each allegation. (Note: a third FIT investigation review was stayed by the FRB pending OPA review. The following summary of **2017-319167** is taken from the Force Investigation Report completed by FIT. Note: the names of the subject, and the involved officers, have been redacted.

> *On August 28, 2017 at approximately 1720 hours, the first of three phone calls came into the Seattle Police 911 Communications Center of a subject walking in traffic. The information on the call indicated, "male walking in the middle of traffic, screaming, pushing bicyclists". Two additional 911 calls provided similar descriptions of the subject's actions. The subject was reported to be walking the wrong way in traffic on 4th Ave. This occurred during the middle of rush hour traffic. The subject was described as a Samoan male, 30's or 40's, 6'4", 250 lbs., heavyset, wearing a grey shirt and black shorts. This subject was later identified as [Subject A].*
>
> *Seattle Police Officer [A] heard the radio broadcast and responded to the area. Seattle Police Officer [B] volunteered to back Officer A. SPD Bike Officers [C] and [D] were located at Westlake Park and announced on the radio they would respond to the call. What follows summarized the events of the Involved Officers and Witness Officer B's encounter with Subject A based on their statements (written and audio) and the video evidence located from this incident:*
>
> *Officers C and D rode northbound on 4th Ave from Westlake Park. They observed Subject A walk southbound in the street on 4th Ave towards oncoming vehicular traffic. Both officers directed Subject A to get out of the roadway. The officers stopped their bikes approximately 10-15 feet away from Subject A. Subject A yelled "Who want it? Who want it?" as he walked directly at the bike officers. Officer D placed his bike as a barrier between himself and Subject A. Subject A walked into Officer D and struck him in the shoulder at least one time with his hands. Officers ordered Subject A to get on the ground and he did not comply.*
>
> *Officer C was positioned to the left side of Officer D. He warned Subject A to get onto the sidewalk or to get onto the ground or he would be tased. Officer C stated Subject A appeared to "square off" on Officer D. Officer C aimed for*

Subject A's lower chest and upper thigh area on the first Taser cartridge deployment. When Officer C deployed his Taser in probe launch mode, it struck Subject A on the right hand and right abdomen area. The Taser application was initially effective causing Neuromuscular Incapacitation (NMI) and Subject A went to the ground on his stomach then he rolled to his back. Officer C got on the air to say they were taking the subject into custody. Officer C and Officer D attempted to place Subject A into custody after the five second Taser cycle. However, Subject A recovered and tried to get up. Officer C stated Subject A swung and kicked at Officer D.

Officer C called for a fast back up as they tried to take Subject A into custody. He described that Subject A attempted to punch him and Officer D. In his statement, Officer C said he delivered at least two knees to Subject A's face as he ordered Subject A to get back onto the ground. Subject A continued attempts to get to his feet. Officer C attempted to cycle his Taser 5 to 6 times during the struggle to deliver an additional 5 second cycle but the Taser did not appear to work. Officer C attempted to deploy the second cartridge but the Taser did not deploy the second cartridge. Officer C turned the Taser off then back on and was then able to deploy the second Taser cartridge. Per his statement, Officer C targeted Subject A's abdomen and upper thigh area with the second Taser cartridge. Officer C reported the probes from cartridge 2 landed in the general area he targeted. He stated the second deployment was successful momentarily but Subject A continued to fight them. into custody. He described that Subject A attempted to punch him and Officer D. In his statement, Officer C said he delivered at least two knees to Subject A's face as he ordered Jones to get back onto the ground. Subject A continued attempts to get to his feet. Officer C attempted to cycle his Taser 5 to 6 times during the struggle to deliver an additional 5 second cycle but the Taser did not appear to work. Officer C attempted to deploy the second cartridge but the Taser did not deploy the second cartridge. Officer C turned the Taser off then back on and was then able to deploy the second Taser cartridge. Per his statement, Officer C targeted Subject A's abdomen and upper thigh area with the second Taser cartridge. Officer C reported the probes from cartridge 2 landed in the general area he targeted. He stated the second deployment was successful momentarily but Subject A continued to fight them.

(Note: a subsequent inspection of the Taser determined a hardware issue with the Taser, resulting in performance failure.)

Officer C recalled Subject A kicked him in the legs at least twice and possibly kicked him in the chest. Officer C reported he was almost kicked in the head when Subject A kicked his feet in the air. Officer C stated he also delivered two kicks to Subject A's side to keep him on the ground.

As a Witness Officer, Officer C observed Officer D utilize his baton and strike Subject A in the upper left arm and back area. Per his statement, he did not witness any other officer use force during the incident. Officer D reported that he had no prior knowledge or contact with Subject A before the incident.

Officer D utilized his less lethal baton to prevent Subject A from further assaults to them and to keep Subject A on the ground. Officer D delivered 3 initial baton strikes to the left side of Subject A's body. He and Officer C continued to struggle with Subject A. Officer D delivered an additional 6 strikes to the left side of Subject A's body. During his audio interview, Officer D recalled approximately 10 baton strikes to the subject during the struggle. He believed he struck the subject in the left arm and shoulder area. Officer D poked Subject A with the tip of his baton in the chest area during the struggle approximately 2 times. Officer D stated this tactic did not appear effective. Officer D also attempted to control the subject's head when he used his baton across the left side of the subject's face. This too, per Officer D was ineffective.

As a Witness Officer, Officer D observed Officer C deploy his Taser. Officer D also witnessed Officer C use knee strikes on Subject A which effectively kept him on the ground as they struggled with him. Per his statement, he did not witness any other officer use force during the incident. Officer D reported that he had no prior knowledge or contact with Subject A before the incident.

Officer A was staged nearby at 4th Ave and Olive Way. He heard the officers struggle on the radio and the request for a fast backup. Officer A stated he observed Subject A violently struggle with officers as he pulled up to the scene. He observed Officer C at the lower half of Subject A's body and Subject A kicking repeatedly. He observed Officer D at the upper half of the subject's body attempting to control the subject. Officer A described in his statement that he heard a Taser cycle but it did not appear to effect Subject A. He stated he did not know which officer deployed the Taser. Officer A did witnessed Officer D strike Subject A with a baton approximately 2 to 3 times

to the left shoulder area of Subject A. Officer A reported a constant struggle with Subject A until multiple officers arrived to control the subject's movements. Per his statement, he did not witness any other officer use force during the incident.

After the force, additional officers arrived and assisted with the control of Subject A by holding his body to the ground with their hands to prevent any further struggle with Jones. Officer E arrived and held down Subject A's legs. Officer B arrived and held down Subject A's right arm. Officer F arrived and held down Subject A's left arm. A/Sgt. G arrived on the scene to screen UOF and supervise the scene. A/Sgt. H also arrived on the scene of the incident to assist with scene control. Medical attention was summoned for Subject A for treatment of his crisis issue and to remove the Taser probes from his right hand and torso area. SFD were called at approximately 1726 hours and arrived at approximately 1733 hours. SFD treated Subject A on the scene and attempted to remove all Taser probes from Subject A but were unable to remove the probe from his right hand. Subject A was transported to Virginia Mason Hospital under hospital guard to have the probe removed.

Backing officers located civilians who witnessed the incident. Approximately ten of the civilian witnesses indicated they observed an aspect of the use of force. These witnesses described seeing or hearing the Taser application, witnessed the baton strikes or witnessed Subject A assault officers. Witness A stated Subject A was in possession of a knife prior to the use of force, but the investigation did not confirm her account. Officers checked the path of the subject and did not locate a knife. All witness information was collected and documented in the GO report and this FIR report.

*A/Sgt. G screened the assault on officers with A/Lt. A of the East Precinct. He then screened the incident with A/Capt. Hirjak of FIT. A/Sgt. G changed location to the hospital where he conducted an interview with Subject A and obtained information regarding the subject's injuries. Subject A had a chipped right front tooth that did not require immediate treatment. Subject A's left shoulder checked negative for fractures after the x-ray. The abrasions on XXXX's knees were cleaned and treated by hospital staff. Subject A had bruises on his left arm, left chest and left back. There was no indication of any head injuries. (**Note**: The Taser probe lodged in the bone of Subject A's hand was ultimately removed and A/Sgt. G delivered it to the FIT office where he turned it over to the primary detective.)*

Detective Steve Corbin and Detective Joe Stankovich responded to Virginia Mason to interview the subject. OPA Sgt. Linda Cook was present during the interview. Detective Corbin led an interview with Subject A. Subject A was read Miranda and agreed to an audio statement. Subject A also signed a medical information release waiver.

Subject A described how he smoked PCP with a friend before the incident. He stated he was irritated with his friend, the weather and at the reaction to medication he was prescribed for a medical condition. Subject A stated he did not recall any of the use of force incident. He recalled that he was surrounded by police and SFD when he came to from his black out. Subject A's audio recorded statement and transcript are the best record of the contact. Photos of the subject and his injuries were taken in the emergency room of Virginia Mason Hospital.

FRB Review: The FRB concluded that officers used sound tactics and de-escalation efforts in this incident. Officers communicated clearly with the subject to get on the ground and comply with their commands. A warning was provided to the subject, prior to the Taser deployment, but was ignored. No additional de-escalation tactics were identified by the Board that the involved officers could have used.

At the time of the FRB deliberation, OPA was reviewing a total of six allegations of excessive force, submitted by an employee at a nearby restaurant, who had observed part of the incident. The FRB accordingly discussed elements around tactics and decision-making, but, per policy, did not rule on the use of force itself.

OPA Review: Following OPA review, the OPA Director issued a **"Not Sustained"** finding with respect to all six allegations, certifying four as a **"Lawful and Proper"** use of force, and certifying two allegations as **"Unfounded."**

The following summary of **2017-303566** is taken from the Force Investigation Report completed by FIT:

On August 16, 2017 Officer A and his first rotation Student Officer B were riding together as 3 David 11. Officer B was driving and Officer A was the passenger. At approximately 2056 hours they were dispatched to 225 Cedar St for a disturbance call (2017-303518). The call stated "In parking lot north of, male hitting a tree with a metal pole." Subsequent updates also added that there were approximately twenty subjects standing around. 3 David 3, Officers C and D were dispatched as the backing unit. Less than a minute later, approximately 2057 hours, 3 David 1, Officer E and Student Officer F

answered up that they would also be en route. Officer E was the passenger, and in plain clothes as Officer F was on his fourth rotation, or his "check out" phase.

Officer G, upon hearing the nature of the call and the potential number of subjects felt that he was close enough and asked dispatch over air to log him to the call (2104 hours).

Officers A and B arrived first, immediately followed by Officers C and D. They both parked in the alley to the north, in the 200 block of Cedar St, facing north. They were just south of the alley entrance/exit to New Horizons Youth Service Shelter (2709 3rd Ave). Officers A, B, D and C exited their vehicles to begin their investigation. Officers F and E arrived at the scene about 30 seconds later and approximately 30 seconds after that Officer G arrived. Both vehicles parked on Cedar St for lack of space in the alley.

DICV captured the following: Approximately two minutes after arriving on scene, Officer B can be heard on DICV making contact with [Subject A] who admitted that he was hitting a tree with a metal pole. Officer B and Officer F continued their investigation while the other Officers on scene took cover positions, keeping their attention on the large amount of youth subjects in the alley and Grange Insurance parking lot.

Less than three minutes into the investigation of Subject A's actions, he can be heard on DICV asking officers if they can make "him" leave. It was determined, based upon the involved officer's audio statements that Subject A was referring to [Subject B], who was interjecting himself into the conversation between Subject A and the investigating officers. Approximately one-minute later Officer C could be heard speaking to all the youth subjects who were sitting on the short retaining wall in the Grange Insurance parking lot (west side of the alley), pointing out the "Conditions of Entry" signs.

Officers C's and D's DICV showed officers contacting Subject A. Officer C is heard having a conversation with Subject B (not visible in the frame) who argued about whether or not he needed to leave the property. Subject B then came into view walking eastbound off the property into the alley. Subject B made it about halfway across the alley when he turned around and proceeded to walk back toward the area where Officer C had asked him to leave. According to Officer C, Subject B told him that he needed to grab his

property. Officer C watched Subject B walk to the retaining wall and planter that had no property on or near it.

Officer C opted to identify Subject B at this time for trespassing and asked him for his identification. Officer C said that Subject B ignored his request and attempted to push by him without providing his identification. Officer C said he put his right hand on Subject B's right shoulder and grabbed Subject B's left wrist with his left hand. Officer C told Subject B to sit down (on the retaining wall). Officer C stated that he immediately was met with verbal resistance from Subject B who told Officer C that he was not going to sit. Officer C said he then used "de minimis" force, putting pressure downward on Subject B's shoulder and pushed him a few steps backward in order to make him sit. Officer C said Subject B resisted him as he did this. As soon as Subject B sat down on the wall Officer C said that Subject B jumped back up and pushed him (Officer C) backwards. Officer C said he believed that Subject B was trying to leave the scene.

The altercation can be heard and the officers can be seen going to assist Officer C. Subject B was yelling and can be heard saying, "… get off my neck!" Subject B also was heard making allegations that the officers choked him. At the time of the physical altercation Officer C's mic picked up the noise of the youth subjects around, and their comments regarding the Officers' actions with Subject B.

According to Officers F, C and D they performed a trained take down of Subject B. Officer C stated that from his initial contact with Subject B, he still maintained control of his right arm and was on his right side. Officer F described that he was on Subject B's left side. He said that he attempted to control Subject B's left arm to bring it behind his back to handcuff him, but Subject B yanked it away. Realizing that Subject B was being resistive Officer F did a body wrap, "bear hugging" Subject B and pinned his left arm to his side. Officer F reported in his statement that he alerted other officers verbally of what he wanted to do saying, "Down to the front!" Simultaneously Officer D approached Subject B from in front of him and took control of Subject B's head.

In his FIT statement Officer D said he placed his left forearm on the right side of Subject B's neck and cupped the back of Subject B's head with his left hand. Officer D did this so he could control Subject B's head. Officer D stated he could not immediately recall what his right arm was doing, but he

believed it was controlling Subject B's right shoulder. Officer D said that he verbally gave the command, "To the front," to Officer C.

The officers all stated that when Subject B went to the ground he was still actively resisting. Officer G recalled in his FIT statement that even though he was mainly acting as a cover officer, when he looked down to check the status of Officers D, F and C he saw they had taken Subject B to the ground and were attempting to handcuff him. Officer G said he saw Subject B had his left arm tucked underneath him and was not willingly putting it behind his back so that he could be handcuffed. Officer G said he tapped Subject B's left wrist and tugged on Subject B's sleeve to let him know which arm he was talking about, at the same time verbally telling Subject B, "Put your arm behind your back." Officer G said he then saw that the officers were able to get leverage and get control of Subject B's left arm.

Officer F was able to put the handcuffs on Subject B. The Officers said they then opted to search Subject B as much as possible while he was still on the ground. After approximately a minute of searching Subject B, they stood him up and walked him in front of the patrol car to finish their search.

Sgt H arrived on the scene at 2119 hours and Officer C screened the arrest with him. Officer C informed Sgt H at this time that Subject B made allegations that they choked him. Sgt H had Officer C place Subject B in the back of the patrol car and transport him back to the precinct. Subject B declined medical treatment.

Once at the precinct Sgt H interviewed Subject B. Subject B made allegations of being choked. Sgt H screened the incident with FIT. Detective Simmons and I interviewed and photographed Subject B at the precinct.

In his statement, Subject B said that "the police officer with the redhead" put his hands on Subject B's throat and that the Officer was holding onto his throat trying to control him. Subject B said he yelled for the Officer to get off of his throat. Subject B stated that he "freaked out" when the Officer grabbed him because he didn't know it was an officer touching him. Subject B admitted that he realized it was officers when he was on the ground but that he continued to struggle because of his throat being grabbed. Subject B said that multiple officers took him down to the ground and put a foot on the left side of his head to control him. Subject B said he did not lose consciousness but said he couldn't breathe and he was a little dizzy. Subject

B said that he had dust in his eyes, his head hurt and he complained of pain due to the handcuffs. Subject B suffered minor abrasions on his wrists from the handcuffs. The injury was photographed. Subject B did not have any other complaints of injury and there were no further visible injuries. Subject B again, declined medical treatment. Officer F (FIT statement page 36). Officer D stated that he did this not only because this is how he was trained, but also because it is necessary to protect someone's head if they are being taken to the ground (FIT statement page 14). The three officers then proceeded to bring Subject B to a prone position on the ground in what Officer D described as a controlled takedown.

Once Subject B was on the ground Officer D said he placed his knee on the lower, back part of Subject B's neck. Officer D stated that he heard Subject B say that "they" (officers) were choking him, so Officer D quickly repositioned his knee further down toward Subject B's back. (FIT statement page 11). Officer D said he realized that even though he moved his knee and saw that no one was near Subject B's neck, Subject B was still yelling that he was being choked.

Subject B was subsequently booked into King County Jail at 0128 hours on August 17th for SMC 12A.08.040, criminal trespass and SMC 12A.16.010, obstructing an officer. He was released at 1654 hours on August 17th, pending charges.

Officers D and C provided involved officer statements for Type III use of force.

Officers G, F, B and A provided witness officer statements for Type III use of force.

Officer F completed a Type II Blue Team entry for the injury to Subject B's wrist.

Officer F suffered abrasions on both knees, and sustained a tear to his uniform pants on the knee. Officer D had a small abrasion on his hand. All injuries were reported to and documented by Sgt H shortly after the incident. All officers returned to work for their following shift.

FRB Review: At the time of the FRB review, OPA had taken review of multiple issues related to force, de-escalation, stops and detentions, and professionalism that had been referred to OPA by the chain of command. The FRB accordingly discussed elements around tactics and decision-making, but, per policy, did not issue findings on either

tactics/decision-making or the use of force. The FRB did conclude, however, that no Type III force was used, finding (a) that no choke/neck hold was applied and there was no indication that officers obstructed the subject's airway while applying force to the subject.

OPA Review: As to the subject's allegation that he was choked, OPA recommended a finding of **"Not Sustained – Inconclusive."** The OPA Director's analysis is as follows:

> *The subject alleged that N[amed] E[mployee] #1 used excessive force against him. The gravamen of the subject's allegation against NE #1 was that NE #1 grabbed his throat. NE #1 reported using force to stop the subject from walking away and then force to take the subject to the ground and to handcuff him. NE #1 denied grabbing the subject's throat. None of the other Named Employees reported witnessing NE #1 grab the subject's throat. Moreover, while one civilian witness recalled that the subject complained that his throat was grabbed, from OPA's review, no civilian witness recounted observing NE #1 grab the subject's throat.*
>
> *With regard to the force that NE #1 reported using, I find that it was reasonable, necessary, and proportional. At the time the force was used, NE #1 had probable cause to arrest the subject for trespass. Moreover, when he tried to do so, the subject resisted those attempts and made physical contact with NE #1. As such, at that time, it was reasonable to use force to stop the subject from making any further contact with NE #1 and to place the subject into custody. The takedown was further necessary to achieve the lawful goal of effectuating the arrest. Based on the circumstances of this case, I do not believe that NE #1 thought that there was any other reasonable alternative to that force. Lastly, I find that the force reported by NE #1 was proportional to the subject's resistance and the fact that the subject had just made physical contact with NE #1.*
>
> *Were the force reported by NE #1 the only force alleged, I would have recommended that this allegation be Not Sustained – Lawful and Proper. However, as discussed above, the subject also complained that NE #1 grabbed his throat and choked him. Had NE #1 done so, that force would have been out of policy under these circumstances. I note that not only did NE #1 deny doing so, but that no other witness reported viewing such actions. That being said, at the time that force was used by NE #1, the subject complained of his throat being grabbed by NE #1 and he consistently reiterated this allegation, identifying NE #1 as the perpetrator. Unfortunately, the video of the force and particularly the instant of when NE*

#1 was alleged to have choked the subject is of low evidentiary value and does not clearly show what exactly happened.

As such, and considering that I cannot conclusively determine that NE #1 did not grab the subject's throat, I recommend that this allegation be Not Sustained – Inconclusive.

Allegations of excessive use of force as to two other officers at the scene were rejected as **"Not Sustained – Unfounded."**

As to referrals relating to the lawfulness of the stop, OPA found all related allegations, against all named employees, to be **"Not Sustained – Lawful and Proper."**

As to referrals relating to professionalism and discretion, OPA found all related allegations, against all named employees, to be "Not Sustained – Lawful and Proper" except in the instance of NE #1 where, for the reasons articulated above, OPA found the allegations to be **"Not Sustained – Inconclusive."**

In Table 4, one crisis-involved use of force case is identified as resulting in death. Although the force used in this incident was only low-level, Type I, because this interaction involved an in-custody death it was investigated by FIT and reviewed by the FRB. The following is from the Force Investigation Report. In addition, body-worn video of this incident can be viewed at http://spdblotter.seattle.gov/2017/11/18/death-investigation-in-north-seattle-2/).

On 11/17/2017, at approximately 23:03:46 hours, Witness A called 911 to report a male in the intersection of Aurora Ave North and North 105th Street. She described the male as an older Native American, "looking panicked and freaking out and showing his phone like he's scared." She stated two other males were walking around him and filming with a phone. She was concerned that the males were going to fight the male in the middle of the road.

At approximately 23:06 hours, Witness B called 911 to report a male in the intersection of Aurora Ave North and North 105th Street, yelling "Help, help, help!" He described him as a Native American Male, holding a phone, saying he needed help. The male was currently alone in the intersection, and Witness B believed the male was in danger of being struck by a vehicle.

At approximately 23:06 hours, Subject A called 911. He reported that a "bunch of people" were chasing him and trying to "kill" him. He stated "I'm

at Northgate. I'm everywhere." As the conversation continued, Subject Fredericks stated he was in the intersection of "105th and Northgate and Aurora." When the dispatcher attempted to gather further information, the line disconnected.

At approximately 23:08 hours, Dispatch called Subject A back. At first, Subject A stated there was an emergency in the middle of the intersection, and he needed help. When the dispatcher asked, "What's going on?" Subject A stated, "I don't know. Nothing. I just need help." He would not answer any other questions. He could be heard yelling in the background, repeating that he hadn't done anything. Car horns could also be heard in the background until the line disconnected.

911 received three more calls regarding Subject A. The callers provided similar information regarding a male in the intersection. Information regarding the calls was broadcasted over North Radio. Officer A and Officer B were working a two-officer car, designated 3N31. They heard the radio traffic and volunteered to take the call. They arrived at approximately 23:12 hours.

As Officers A and B arrived with their emergency lights activated, Subject A was in the intersection; he matched the description provided by the 911 callers. From their vehicle, both officers told Subject A to get out of the street and go to the sidewalk. After several commands, Subject A complied and walked to the sidewalk on the SE corner, on the north side of Seattle's Family Dentistry. Officer A parked the patrol car at the SE corner of the intersection and both officers approached Subject Fredericks on foot.

Subject A told the officers that someone was chasing him. When asked by who, Subject A stated he knew who they were, but refused to provide further details. Subject A talked about unknown subjects disabling video and being "…here still" as he pointed to various locations around the intersection. Officer B told Subject A that it was his choice to identify the subjects, but he needed to stay out of the street. Subject A stated, "I am not going back on the street." Subject A then stated that he needed an escort.

Officer A asked Subject A where he lived and Subject A told the officers that he lived at 120th and Aurora. Officer A asked Subject A if he was going home. Subject A responded by saying, "I'm trying to get there." Officer A offered to

give him a ride home and told him that, "Nobody's going to chase us." Subject A stated he didn't know because he didn't trust them yet. Both officers continued attempts to convince Subject A to allow them to drive him home.

When Officer B asked why he didn't want a ride, Subject A responded by saying "Cause a dispatcher when I call, it didn't even sound like a dispatcher." Officer B asked if he was worried that they weren't the police and Subject A said he was concerned about them not being police officers. When Officer B asked why he felt that way, Subject A said he didn't know. When Officer B told him that he called 911, Subject A told them it wasn't the right number.

A warrant was located from Westport PD. The officers made several more attempts to convince Subject A to allow them to drive him home. He continued to refuse and stated he would go back into the roadway. They told him, if he returned to the intersection they would send him to the hospital. They told him he had two options, hospital or home. After approximately ten minutes of contact, Officer B and Officer A broke contact with Subject A. In their statements, both officers stated, since their de-escalation attempts during the initial contact failed, they would break contact and observe.

Officer A and Officer B immediately drove to the parking between Seattle Family Dentistry and Sherwin-Williams. They began monitoring Subject A and observed him return to the intersection where he was at risk of being struck by a vehicle. Officer A began checking the MDT for available units and made a request via radio for "one more unit to our location." Officer C (3J1) was dispatched to assist.

Officer B observed a Metro Bus almost strike Subject A. They decided to reinitiate contact before the second unit arrived. In his statement later provided to FIT, Officer B described a brief feeling of panic because he lost sight of Subject A and believed a bus had struck him. When he was able to see Subject A again, he believed it was clear that they needed to remove Subject A from the intersection.

At approximately 23:23 hours, Witness B called back to 911 and reported that the male had returned to the intersection. As he spoke to the call-taker, he observed the patrol car return to the intersection and the officers

reinitiate contact. He continued to observe the incident and later provided a statement to investigators.

As the officers arrived at the intersection with their emergency lights activated, they contacted Subject A a second time. Officer B rolled down his window and told Subject A to go to the sidewalk. He also informed Subject A that another police car was on the way. Subject A did not comply. Officer A parked the patrol car at the Southeast corner of the intersection. Officer A and Officer B approached on foot.

As they approached Subject A, Officer B repeated that another car was coming and he told Subject A to come with them. Subject A yelled "No" several times and turned away from the officers. He began walking south in the northbound turn lane. Officer B reached toward Subject A, lowered his voice and said, "Come on buddy." When Officer B made contact with Subject A, Subject A began screaming "No. Where are you taking me?"

Officer B took hold of Subject A's left arm and placed it in what Officer B later described as an escort position, "...left hand on his wrist. Right hand on his elbow." Officer A took hold of the right arm. Both officers described Subject A's reaction as "tensing" his muscles. As they escorted him out of the street, they repeatedly explained that they needed to get out of the road. Subject A told the officers that he would stay right there.

As they approached the sidewalk, Subject A appeared to continue to struggle. He pushed and pulled as the officers maintained hold of his arms. Officer A repeatedly told Subject A that he needed to get out of the street. Officer B said, "We just want to help you, buddy." Subject A began to push and pull as Officer B told him to stop fighting. He broke away from Officer A and began to move toward the intersection. Subject A continued to yell for help as he struggled.

To prevent Subject A from breaking free and returning to the intersection, the officers decided to take Subject A to the ground. Officer A described the takedown. Officer B placed his right leg behind Subject A's left leg, while Officer A placed his right leg behind Subject A's right leg. Both officers pushed him in a backwards direction to the ground.

The completion of the takedown resulted in Subject A on his back with Officer A holding his left arm and Officer B holding the right arm. Officer A

patted Subject A's chest while saying, "There you go. There you go. It's ok. It's ok. [Subject name], it's ok, it's ok, breathe. Breathe. Breathe." Subject A yelled that he was not getting in their vehicle and that he needed an ambulance. Officer A told Subject A that he was not getting in their car and Officer B told him they would get an ambulance. Officer B requested an ambulance via radio.

Subject A appeared to continue to struggle and begin to sit up. He stated, "I never done drugs" and continued to yell for an ambulance. Subject A was able to get to his knees and struggled to stand as Officer A and Officer B maintained control of his arms. Officer A and Officer B pushed him back to the ground until he was on his right side. Both officers continued to give commands.

Subject A continued to struggle in an apparent attempt to stand up. Officer A and Officer B were able to get him on his back. An unknown female approached the struggle and stated, "Stop fighting them, dude. Stop fighting them. Stop fighting them. No, you need to stop fighting them. Relax. Relax…" As the sirens from the backing units approached, Subject A stated, "Here come the real cops." He continued to struggle and yell while he was still on his back. They maintained that position until backup units arrived.

Officer D, Officer E, and Officer F assisted with getting control of Subject A. They rolled Subject A onto his stomach. Officer G stood by and provided light to the officers. Officer F and Officer B took control of his arms as Officer E and Officer D took control of his legs. Officer A had his left hand on Subject A back as he used his right hand to assist Officer B with gaining control of Subject A's left arm. Officer B and Officer F held Subject A's arms behind his back as Officer Rogers applied the handcuffs. Subject A said "ow" several times as the handcuffs were applied.

According to body camera footage, Subject A was on his stomach for approximately one minute and thirty seconds during the handcuffing process. After the handcuffs were applied, Subject A was no longer struggling. Officers rolled Subject A onto his side into the recovery position. At that time, the American Medical Response ambulance arrived on scene. Officer E asked if Subject A was snoring and subsequently asked if he was breathing. Officer F stated he could hear Subject A breathing. Body camera video captured what sounded like snoring emanating from Subject A.

The AMR crew consisting of Emergency Medical Technician A and Emergency Medical Technician B approached the officers with their gurney. Officers assisted by lifting Subject A onto the gurney and removing the handcuffs. EMT A and EMT B placed Subject A in soft restraints and placed him into the back of their ambulance. The EMTs began evaluating Subject A EMT A checked for a carotid pulse and later stated that he detected a "thready" pulse of approximately 40 beats per minute. Officer B asked EMT B if he needed Fire to respond and he replied, "I don't think so, I think it's purposeful." Officer B stayed near the back of the ambulance as Officer A screened the incident with Sgt. A.

Officer B requested the ambulance to move out of the roadway, to the parking lot between Sherwin-Williams and the Seattle Family Dentistry. Officer A began the paperwork necessary for the Involuntary Treatment Act. EMT A drove the ambulance to the parking lot as EMT B stayed in the back with Subject A. After moving the ambulance, EMT A returned to the back of the ambulance. Officer B returned to standing by the rear door of the ambulance and observed the EMTs providing treatment to Subject A. EMT A checked for the carotid pulse a second time but was unable to locate it. EMT A advised that he could not find a pulse and stated he wasn't breathing. Officer B called for Fire to respond. The EMTs began performing CPR on Subject A. Officer B updated via radio that CPR was in progress. Seattle Fire responded and continued CPR for approximately twenty-four minutes before declaring Subject A deceased.

A subsequent autopsy determined the primary cause of death to be acute combined methamphetamine and alcohol intoxication; the manner of death was ruled accidental.

As it involved an in-custody death, the FRB reviewed the Type I use of force in this case. The FRB found that officers performed commendably; that they employed all feasible de-escalation efforts; and that the force used was reasonable, necessary, and proportional to the subject's resistance. The OPA Director was present at this FRB and declined to initiate any review.

IV. Crisis Response Unit Monitoring, Review, and Mitigation of Force

The Crisis Response Unit consists of 1 sergeant, 5 officers and 1 mental health professional (MHP). Throughout the study period and ongoing, CRU has maintained its standing mission of supporting Patrol with direct field-response, assessing Crisis related reports for appropriate follow up to include potential Response Plans, and coordinating with service

providers and partner agencies. By way of example, in 2018 alone, CRU personnel responded to over **1,200 patrol calls**, coordinated **nearly 400 meetings** with service partners (including regular meetings with the Crisis Intervention Committee), and conducted follow-up on over 700 incidents.

In addition to their field and follow-up work, CRU maintains situational awareness of crisis-involved activity throughout the city in two significant ways, at both an incident level and through aggregate review.

At the incident level, a CRU sergeant is responsible for reviewing all Significant Incident Reports (SIRs)[7] and ensuring, for those that contain crisis indicators, that a crisis template has been completed for that subject. In addition, where exceptional work is noted, the Sergeant may retain those SIRs for purposes of informing future training and/or commendations. Thus, for purposes of answering questions that have come up as to how SPD measures de-escalation in instances in which no force is used, incident-specific review in crisis cases, which are inherently more likely to involve force at some level, provides one such measure of oversight. Examples of some such SIRs generated within the study period are included below for illustrative purposes.

2017-151250	Crisis
Precinct: NORTH	U1 Third Watch
Date: 05/01/2017	Time: 0250
Created by:	Stone, Steven

Patrol officers responded to a report of a man with a gun threatening to kill himself and his roommates. The caller was one of the roommates who was able to get out of the house. A crisis team and containment was established. The caller further reported she saw the suspect hold a gun to his chest while naming off the roommates he was going to kill in order. SWAT/HNT responded to the scene. A Mandarin interpreter was contacted via communications and the complainant was interviewed again in her native language. After approximately twenty minutes of interviewing the complainant in her native language it was determined the complainant was in crisis. Patrol officers conducted a welfare check of the roommates and learned they were fine. The caller went to the hospital for a voluntary mental health evaluation. 221 and 271 responded to the scene. Car 88 was notified.

[7] Significant incidents include any incident involving an assault with serious injury, bias crime, circumstances likely to generate media attention and/or community concern, homicide, hostage/barricade, in-custody death, assault on officer, robbery, shots fired, significant crisis incidents, including those resolved without force, Type II and Type III use of force, and any other event a sergeant believes to be significant. The purpose of the SIR is to provide command staff with rapid notification of significant incident, to inform sergeants, lieutenants, and captains of potential cross-precinct issues to enhance officer safety and incident investigation, and to make specific information about significant events directly and quickly available to officers and detectives to improve officer communication and safety. See SPD Manual Section 15.350.

2017-237314	Crisis with Knife
Precinct: SOUTH	O3 First Watch
Date: 07/01/2017	Time: 0854
Created by:	Burrows, David

At approximately 0850 HRS, the subject parked his truck at the Boeing parking lot which is located at the 7500 BLK of E Marginal Wy S. Boeing staff called SPD about the incident.The subject cut himself and he had a knife to his neck. Boeing staff and officers barricaded the subject's vehicle in. The subject kept threatening a suicide by cop and that he wanted to be shot by police. Multiple CIT Certified Officers were on scene and tried to de-escalate the situation. HNT was requested and en route to the location. I arrived on scene and I saw that the male inside the truck had a knife to his neck and he was trying to bait police to engage him. The subject wanted to be shot by police. I confirmed that the subject was inside the vehicle by himself, and that he didn't commit any crimes. Once I confirmed the status of the incident, I had officers safely move vehicles to allow an exit for the subject. The subject drove away, and left on E. Marginal Wy S. A Hazard Report was completed and dispatch broadcasted the subject's information over radio.

2017-149251	Arrest-Threats to Kill Officer
Precinct: WEST	Q3 First Watch
Date: 04/29/2017	Time: 0947
Created by:	, Hilton, Shaun

A 911 caller reported a man yelling to himself and waving a 5-inch knife around near the Seattle Center grounds near wear groups of children were gathering. Officers responded to the area and were continually updated with the suspect's location by multiple callers. Officers eventually caught up to him at a nearby parking garage. There, the suspect turned on a uniformed police officer, made stabbing motions with a fixed blade knife and verbally threatened to kill him with the knife. The suspect fled and sought refuge on top of a roof of the parking garage. HNT was called and the area locked down. CIT certified patrol officers formed a team and were able to successfully negotiate multiple knives and other weapons away from the suspect, talk him down from the roof and take him into custody without any further incident.

2017-108552	Crisis
Precinct: WEST	M3 Second Watch
Date: 03/28/2017	Time: 1402
Created by:	Schenck, Scott I.

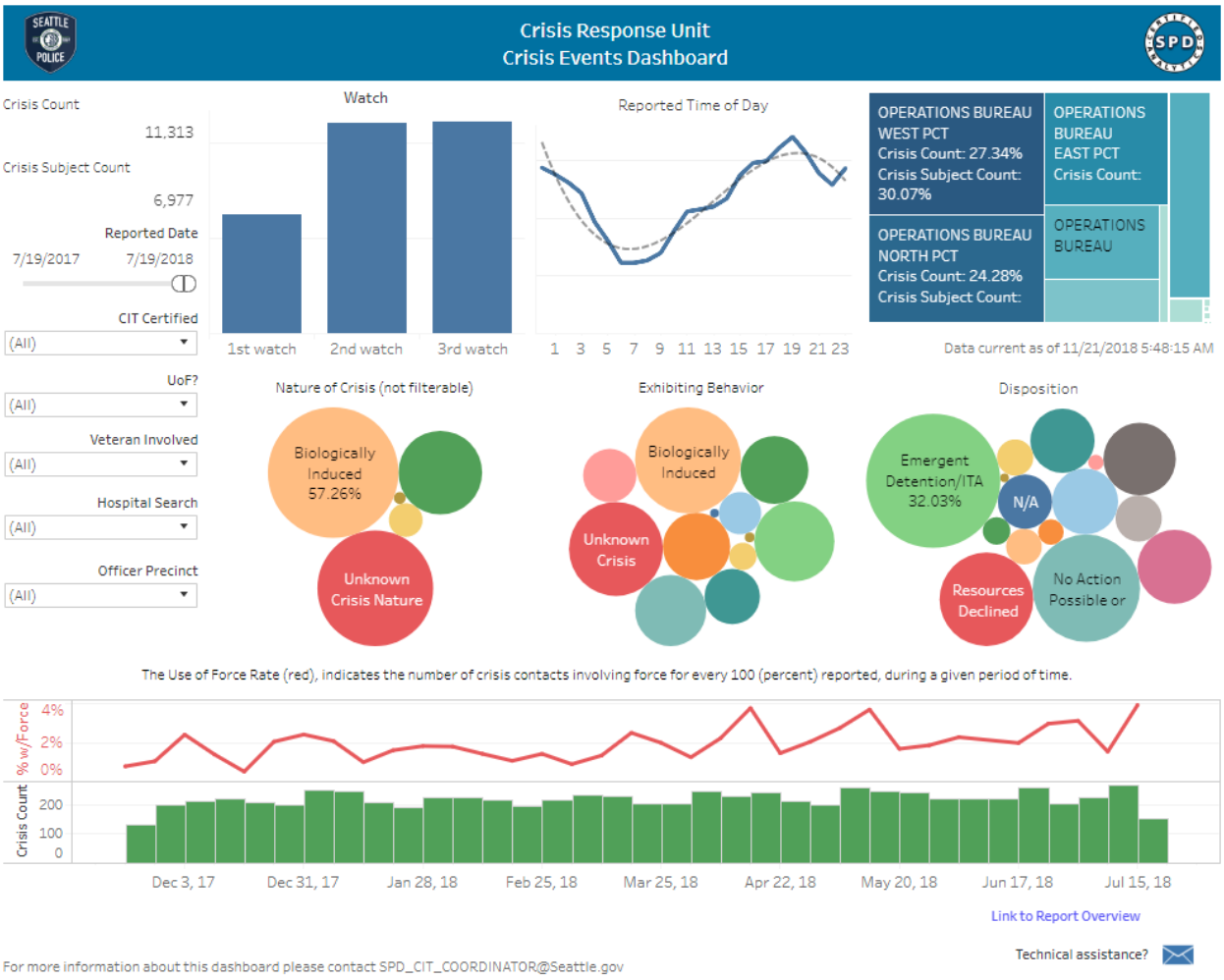
On 3-28-17 around 1400 hours officers responded to a man with a knife in the 1200 block of 3 AV. The streets and sidewalks were very crowded. The officers arrived to find the subject standing in the middle of the street with a knife in his hand. He repeatedly demanded that officers shoot him as he moved closer to them. Streets were shut down and the sidewalks were cleared. Officers on scene did an excellent job of containing and communicating with the subject. They kept him away from the passersby. Attempts to get the subject to drop the knife were ignored and the subject moved closer to officers yelling ?pull it? and ?come on, do it.? CIT, HNT and SWAT were called to the scene. After more than two hours of negotiation, the subject surrendered and was taken into custody. He was later sent to HMC for a Mental Health Evaluation.

2017-44742	Crisis
Precinct: WEST	D2 First Watch
Date: 02/06/2017	Time: 0820
Created by:	Bennett, Anthony

On February 6, 2017 at 0820 hours, Officers were dispatched to 2025 Terry AV, in regards to male threatening to jump off the roof, which is on the twentieth floor of the building. Upon arrival, Officers went up to the roof and they observed the male standing on the edge of the roof. The male told Officers he was hearing voices and he wanted to jump. Officers were able to start a dialogue with the male, as the waited for additional resources and SFD personnel. While speaking with Officers, the male removed his prosthetic leg and appeared to be preparing to jump. Officers were able to calm the male down. After a few minutes, Officers were able to convince the male to back away from the edge of the roof. The male told Officers he no longer wanted to jump and he needed help. Officers, along with SFD personnel, assisted the male off of the roof and walked him back into the building where they were met by AMR medics. Officers transferred custody of the male to AMR medics without incident. AMR transported the male to HMC for a (ITA) psychiatric evaluation.

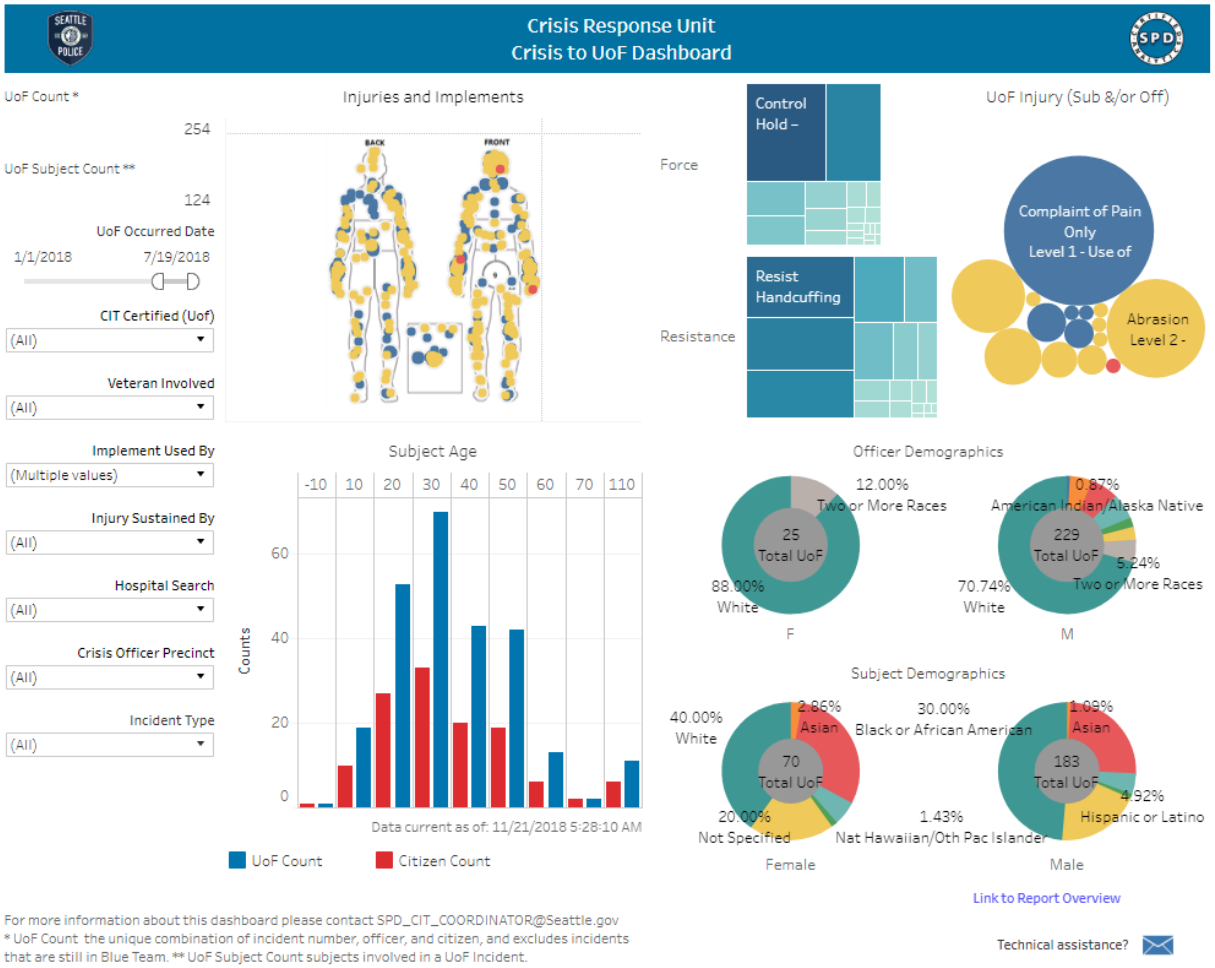
At the aggregate level, city-wide, the CRU monitors a series of dashboards that allow for ready queries into SPD's crisis data. The dashboard shown in Figure 3 displays all crisis responses city-wide, query-able by precinct and watch. Data can further be parsed by subject characteristics, whether the officer is CIT-certified, nature of crisis, disposition, and whether force was involved.

Figure 3: Crisis Events Dashboard



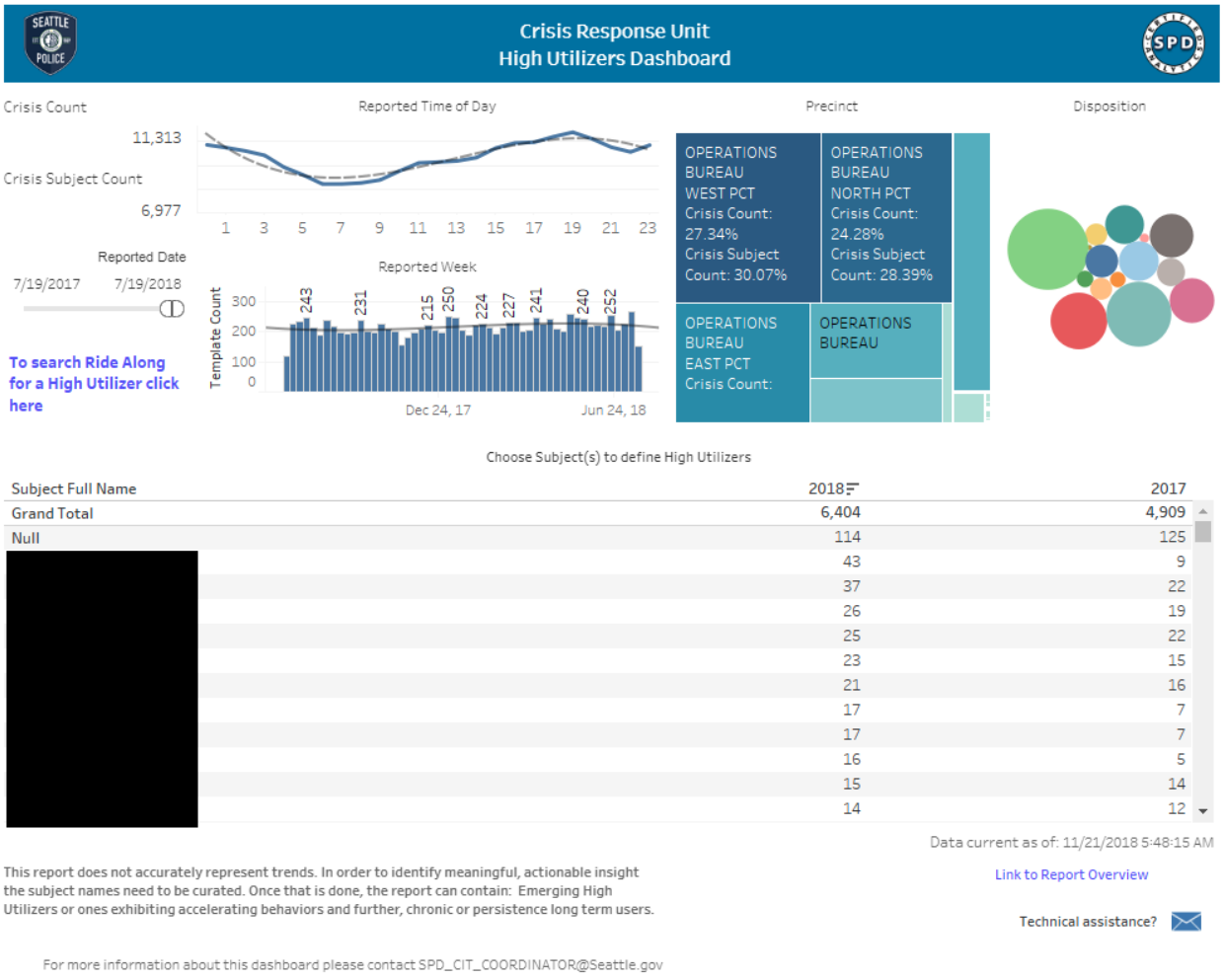
A second dashboard Figure 4 presents data for those crisis incidents associated with a use of force, searchable by nature of injury, type of force, nature of force, subject resistance, and subject and officer characteristics. (Note: a CRU sergeant represents the unit on the FRB and serves as a subject matter expert in force cases involving a subject in crisis.)

Figure 4: Crisis to Use of Force Dashboard



A third dashboard (Figure 5) provides information concerning high-frequency utilizers (names redacted) of crisis intervention services. The CRU is responsible for creating and maintaining individualized profiles of subjects of crisis incidents, for purposes of potentially informing future responses. As Crisis Templates are completed by officers, the data points are captured and then populated into a custom application platform (currently, RideAlong). A "profile" is created in RideAlong for each individual when a template is completed; additional interactions with such individuals further populate the data contained within each profile.

Figure 5: High Utilizers Dashboard



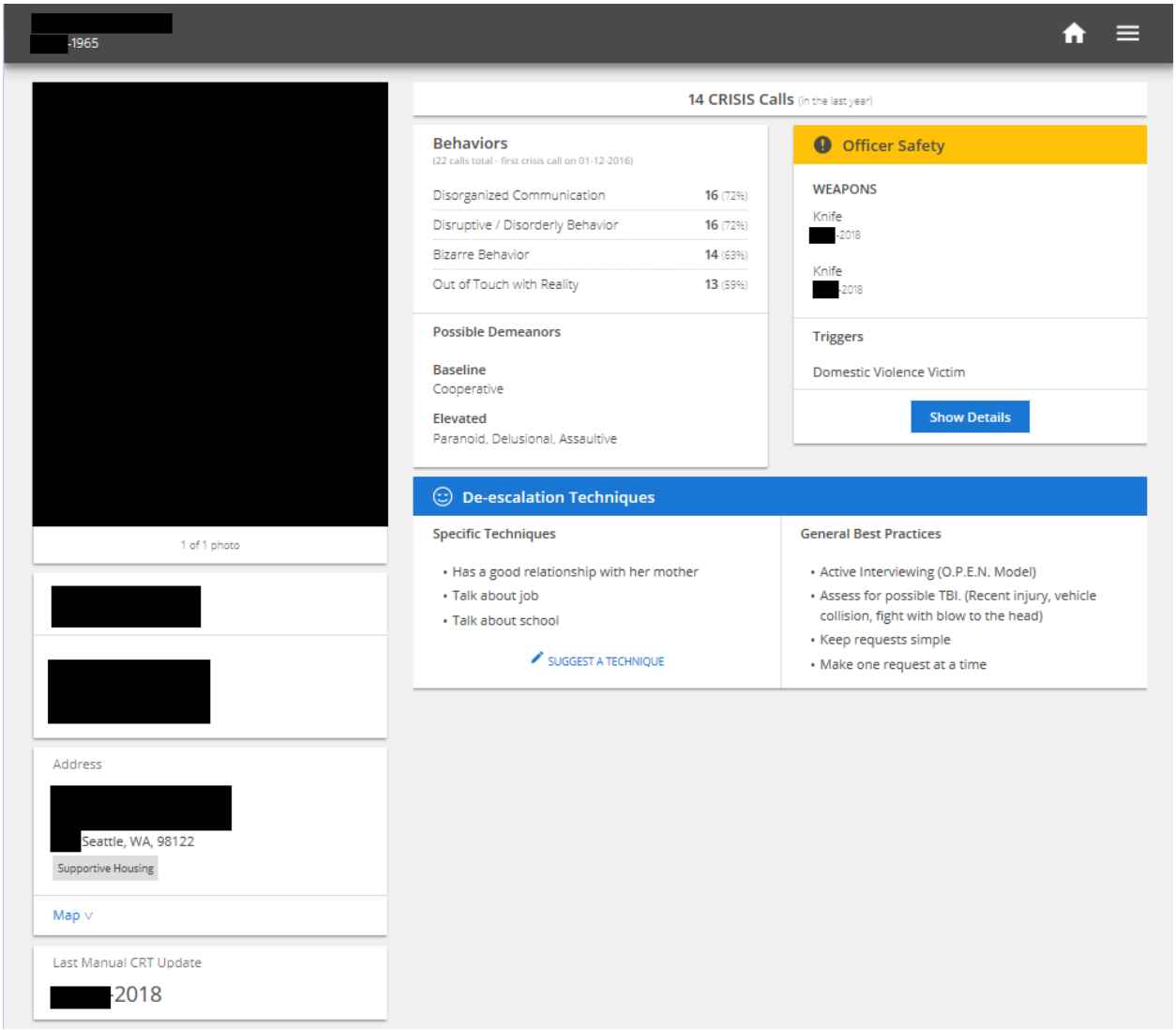
While profiles are created for all subjects of crisis templates, the designation of a 'high-utilizer' takes multiple factors into consideration, including the number of crisis contacts within a rolling 365-day period, whether an individual was involved in a high-risk crisis call requiring a large number of resources or presenting an on-going safety concern and the volume of calls to the 911 center.

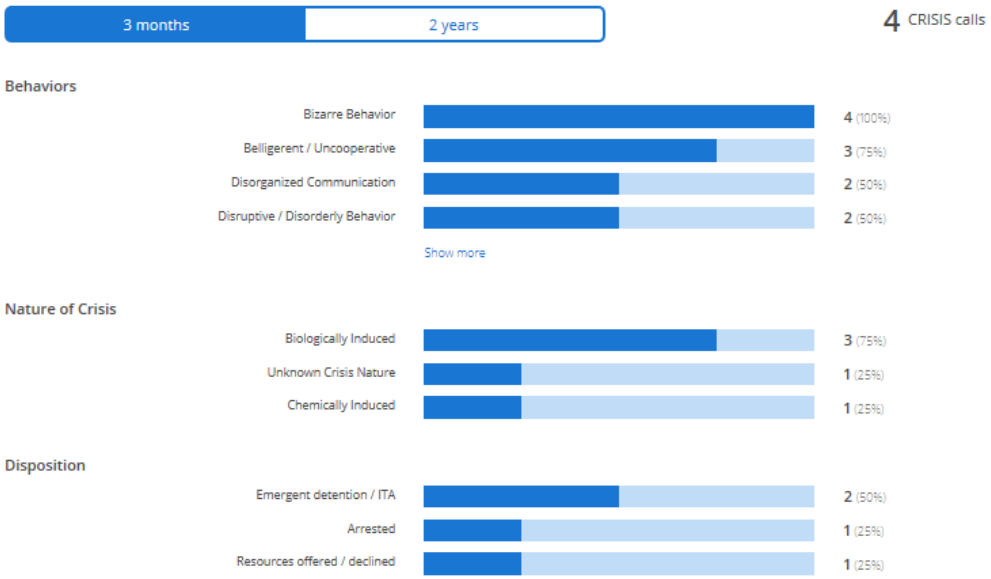
Response Plans are developed for those individuals deemed as high-utilizers and where a consistent structured approach by patrol officers would be beneficial. While some individuals do not necessitate a full Response Plan, relevant information exists that could assist patrol with future encounters – such as case manager contact information, service providers, specific 'hooks' that could prove successful during de-escalation efforts, etc. In those instances, the CRU adds information into RideAlong – creating an 'extended' profile and making it visible to Patrol. The CRU also

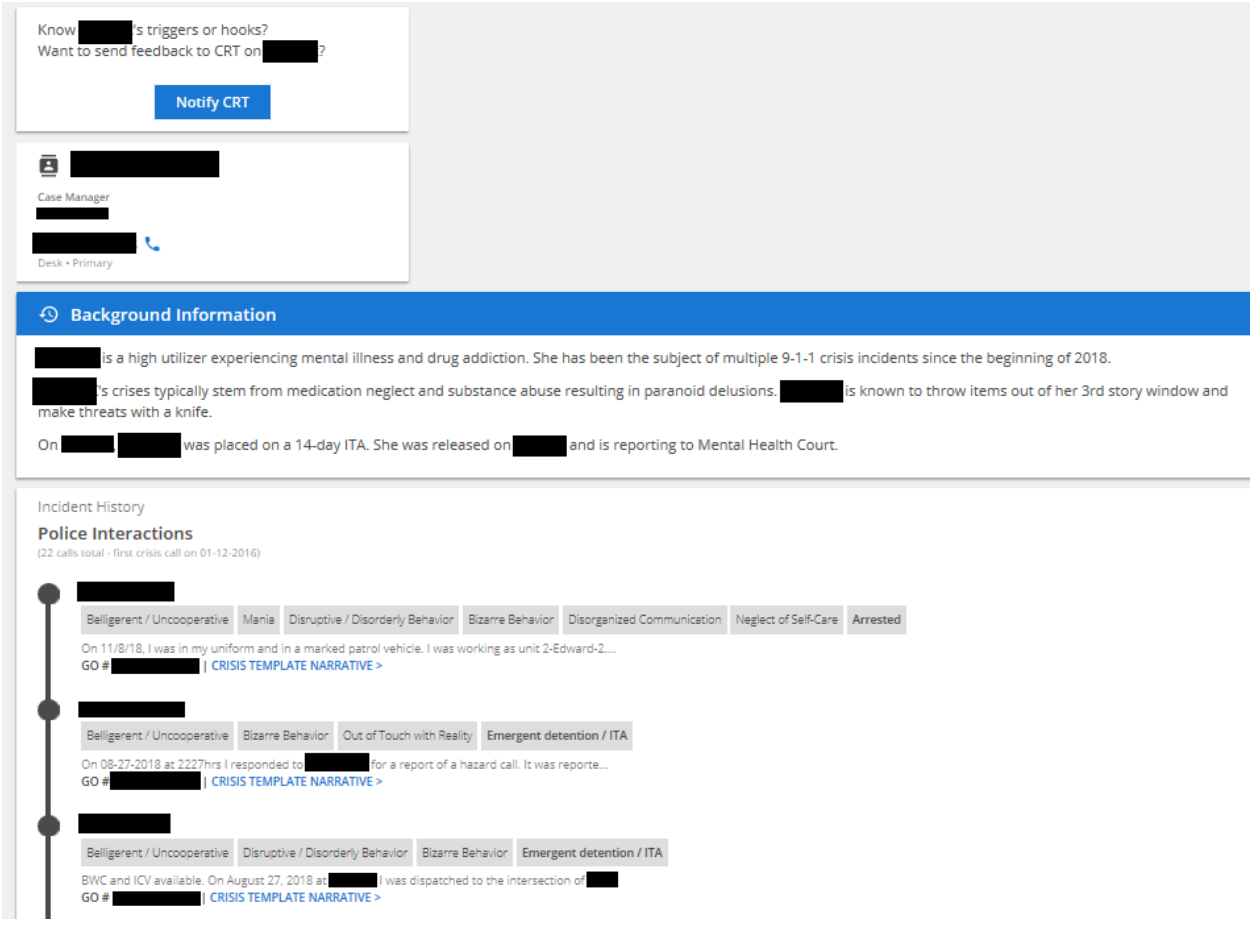
disseminates Officer Safety Bulletins as appropriate. In 2018, the CRU has published 26 specific Response Plans and an additional 43 Bulletins.

An example (redacted) of such a profile is shown in Figure 6, as screenshots of the information officers have available to review in the field, which they may rely on in informing their approach to the individual or the disposition of the event.

Figure 6: Example of High Utilizer Profile




3 months
2 years
4 CRISIS calls
Behaviors
Bizarre Behavior
4 (100%)
Belligerent / Uncooperative
3 (75%)
Disorganized Communication
2 (50%)
Disruptive / Disorderly Behavior
2 (50%)
Show more
Nature of Crisis
Biologically Induced
3 (75%)
Unknown Crisis Nature
1 (25%)
Chemically Induced
1 (25%)
Disposition
Emergent detention / ITA
2 (50%)
Arrested
1 (25%)
Resources offered / declined
1 (25%)


Know [redacted]'s triggers or hooks?
Want to send feedback to CRT on [redacted]?
Notify CRT
[redacted]
Case Manager
[redacted]
Desk • Primary
Background Information
[redacted] is a high utilizer experiencing mental illness and drug addiction. She has been the subject of multiple 9-1-1 crisis incidents since the beginning of 2018.
[redacted]'s crises typically stem from medication neglect and substance abuse resulting in paranoid delusions. [redacted] is known to throw items out of her 3rd story window and make threats with a knife.
On [redacted] [redacted] was placed on a 14-day ITA. She was released on [redacted] and is reporting to Mental Health Court.
Incident History
Police Interactions
(22 calls total - first crisis call on 01-12-2016)
[redacted]
Belligerent / Uncooperative
Mania
Disruptive / Disorderly Behavior
Bizarre Behavior
Disorganized Communication
Neglect of Self-Care
Arrested
On 11/8/18, I was in my uniform and in a marked patrol vehicle. I was working as unit 2-Edward-2....
GO # [redacted] | CRISIS TEMPLATE NARRATIVE >
[redacted]
Belligerent / Uncooperative
Bizarre Behavior
Out of Touch with Reality
Emergent detention / ITA
On 08-27-2018 at 2227hrs I responded to [redacted] for a report of a hazard call. It was reporte...
GO # [redacted] | CRISIS TEMPLATE NARRATIVE >
[redacted]
Belligerent / Uncooperative
Disruptive / Disorderly Behavior
Bizarre Behavior
Emergent detention / ITA
BWC and ICV available. On August 27, 2018 at [redacted] I was dispatched to the intersection of [redacted]
GO # [redacted] | CRISIS TEMPLATE NARRATIVE >

Incident No. 18-020083, a Type II use of force event discussed above in Table 10, provides a good illustration of how response plans contained in the RideAlong application inform responses in the field. In this case, which involved a subject who had disrobed, was running around in the street, barricading himself in a trashcan, and was otherwise aggressive towards officers, the subject's profile noted a violent history associated with drug use. Because the root cause of the subject's behavior was known to be drug related, rather than due to an underlying mental health condition, the response plan called for an arrest of the subject where probable cause to do so exists, rather than seeking an Involuntary Treatment Act detainer, which had been ineffective in the past. Officers on-scene further sought to offer a blanket, cigarettes, and music to the subject in an effort to achieve cooperation and compliance, based on suggestions in the response plan. Though ultimately unsuccessful in resolving the incident without the need for force, officers were able to call upon information in this application to potentially diffuse what may have resulted in a higher level of force otherwise.

The high-utilizers dashboard assists in the Department in being able to answer *ad hoc* queries as well. In a recent discussion, for example, a question was raised as to whether there were any unusual patterns or frequencies of use of force involving subjects who were deemed high utilizers of crisis intervention services. For purposes of examining this question, SPD examined all crisis and use of force incidents across the study period (January 1, 2017 – June 30, 2018) that were associated with a known subject. Just five individuals were involved in a crisis contact associated with a reportable use of force more than once: Four of these five subjects were involved in two separate crisis-involved use of force events each; one was involved in three.

Expanding the study period to the universe of crisis events associated with a use of force, as of the time of this drafting (May 15, 2015 to November 25, 2018, *n = 627*), one subject was involved in five separate crisis-involved use of force events; two individuals were involved in four separate events. Five individuals were involved in three separate events, and 31 individuals were involved in two each. In other words, of the 627 unique events with both a crisis template and use of force associated, approximately 14% (*n*=90) involved one of 39 repeat subjects, none of which were involved in any greater than five incidents. Considering the substantial number of individuals listed as high-utilizers with crisis contacts far exceeding these numbers (see Figure 5), it is fair to say that the low number and sporadic nature of these "high utilizer involved" force incidents across both the study period and the total universe of crisis involved use of force data do not support any meaningful inquiry in terms of pattern or trend analysis. Notwithstanding, CRU performed a cross-check to determine the number of these individuals with established

response plans in RideAlong. Of the nine individuals identified as subjects in three or more separate crisis-involved use of force events, all have CRU profiles; three of which, however, are inactive due to inactivity. Four subjects have full response plans on file, all with officer safety flag cautions.

Additionally, the ability to pair a subject not only with the number of crisis-related force incidents but the number of uses of force in each incident allows the CRU to examine any trends or outliers that might indicate escalating behavior. One such example can be seen with respect to one individual who was involved in three separate crisis-involved use of force incidents over the course of one year, involving a total of 19 separate uses of force – 6 associated with the first, 2 associated with the second, and 11 associated with the third. Reviewing each of these incidents shows not only escalating behavior, but highlights the opportunities to engage more systemically in intervention options.

- In the first contact with this individual, SPD responded to a suspicious person call where the subject appeared to be in a crisis state, with behavior that was bordering on excited delirium (keening, growling, barking). During the investigation, officers identified and verified a warrant. During the arrest process, the subject lost all behavioral control which resulted in a "help the officer" call out. SFD ultimately administered Ketamine to the subject. At the time of this incident, the individual was not tiered with any mental health agency, per the crisis clinic.

- In the second incident, officers on-viewed a disturbance at the Union Gospel Mission where several clients were chasing the subject down the sidewalk. After containing to the subject and listening to the pursuers, it was learned that the subject had stolen puppy from another client. At one point in the contact the officer patted the subject in a reassuring way, which resulted in the subject dropping to the ground and crying out in pain. Following arrest, the subject made numerous injury claims (including a broken leg, which resulted in a Type II use of force investigation).

- In the third incident, radio had broadcast a city-wide Amber Alert that a male subject (identified as the subject in the above-two incidents) had taken his five-year-old child at knife point from the grandparents and might be heading to Seattle from Lake Forest Park. A description of the vehicle being driven by the subject was given during the Amber Alert, and multiple citizens called 911, gave the location of the vehicle, and reported that the child was in the front seat. Officers responded to the area, located the subject vehicle, and attempted to stop it. The subject refused to stop of officers and attempted to elude them. As the subject fled, he rammed two officers' vehicles

with his own, and then drove onto the sidewalk. Several officers rammed/pinned the subject's vehicle in with their patrol vehicles to disable it. Once the subject's vehicle was unable to move further, officers approached the vehicle. The subject attempted to take hold of the child and use him as a shield, but officers were able to use verbal persuasion to rescue the child and take the subject into custody.

What makes this case stand out is the impact that recent legislative changes to RCW 71.05.153, had they been in place at the time, might have had as an intervention between the second and third incident with this subject, and in highlighting the importance of this legislation in providing opportunities now and in the future.

In the second incident, the subject was found to be in possession of methamphetamine – likely a significant factor in his erratic behavior. During the 2016 legislative session, a bill ("Ricky's Law") was presented which would add "Substance Use Disorder" to the criterial for an emergent detention under the Involuntary Treatment Act (ITA) outline in RCW 71.05.153. Based on data from SPD' crisis templates, which showed substance use disorder listed as a possibly underlying cause in nearly a quarter of all crisis incidents, SPD's crisis coordinator (Sgt. Dan Nelson) was asked by the co-author of the bill to provide testimony to the state legislature, which he did – arguing that individuals who were struggling with the disease, were suicidal, and were needing involuntary treatment were left out of the system of care, forcing them to continue a pattern of substance use, self-harm, and potential harm to others. Due to the large fiscal impact of the legislation, the bill did not pass in 2016, but was introduced and was passed in 2017 with broad bipartisan support.

Many of the CRU's "high utilizers" come to police attention because of crisis behavior attributed to substance use disorder. Prior to Ricky's Law, officers would often bring subjects in crisis to the Emergency Room pursuant to the ITA, only to have it medically determined that their behavior (often lack of control or suicidality) was the result of substance use disorder, and they would be released. This resulted in an alarming rate of recidivism amongst this population, which no option for involuntary services.

Pursuant to this legislation, the secured detox facility in King County is scheduled to open in 2019. Once that facility is open, the King County Designated Crisis Responders will be able to detain individuals to one of the secured 16 detox beds, to hopefully provide the individual with meaningful and appropriate treatment. Had this option been available in 2017, when officers responded to the second incident and found methamphetamine on the individual, such intervention may have disrupted behavior that may have eventually led to the third incident.

Separate and apart from its heavy workload around its core mission of providing analytical and field support around crisis incidents and responses, the CRU has additionally, beginning in mid-2017, absorbed two new bodies of work associated with other legislative changes, both of which likewise serve to either provide new connections to services or reduce the likelihood of harm. Sheena's Law (RCW 71.05.458) enables law enforcement officers to refer directly to mental health professionals individuals who fall short of the legal threshold for involuntary detainment but still may pose a threat of harm to themselves or others). The Extreme Risk Protection Order (ERPO) Act (RCW 7.94) enables family members or law enforcement agencies to petition a court to temporarily prevent individuals who are at high risk of harming themselves or others from accessing firearms.

Since these laws went into effect, the CRU has made nearly **650** direct referrals under Sheena's Law to King County Designated Crisis Responders, and has assessed **90** individuals for criteria meeting an ERPO. In **40** of those instances, CRU personnel sought, and secured, court orders, pursuant to which the CRU has since secured **93** firearms from 33 individuals, arguably saving lives and proactively mitigating the need to use force in eventual responses.[8]

Finally, at a regional level, the CRU has been integral in leading the charge to expand the cross-disciplinary approach, which in nascent form was limited to Seattle's Crisis Intervention Committee, to addressing behaviors that fall in the widening intersection between public safety and public health. While Seattle's Crisis Intervention Committee continues to meet quarterly, includes regular participants from local hospitals, mental health service providers, and social service providers, and continues to review updates to data collection, training, and policy, Sgt. Nelson also serves as the Vice-Chair of the King County Behavioral Health Advisory Board. In this role, he helps to plan both regional and international CIT conferences and participates in monthly Regional CIT Coordinators meetings, hosted by the Washington State Criminal Justice Commission. The primary purpose of these meetings is to synthesize the Crisis Intervention Committee process around program development, legal updates, data collection, advocacy, and co-responder programming for agencies who are in the process of standing up their own Crisis Response Units or Crisis Intervention Committees. Other participating agencies include the King County Sheriff's Office; Kirkland, Redmond, Tukwila, Issaquah, Port of Seattle, Auburn, Lake Forest Park, and Bellevue Police Departments; the Washington State Patrol; SCORE (South Correctional Entity) Jail; King County Behavioral Health and Recovery Division, and the King County Mental Illness and Drug Dependency Program.

[8] The workload associated with these new bodies of work is not insubstantial, averaging nearly 50 hours of work per pay period.

Collectively, through its participation on the FRB, its engagement with the CIC locally and regionally, its analytical work, and its incident-based review of each crisis-involved incident, the CRU continues to hold a vital position in ensuring not only that each crisis event and each crisis-involved force event is critically reviewed, but in harnessing its experience, and its data, to advance policies, training, practices, and key legislative changes that all serve to mitigate, to the extent possible, negative interactions – including foremost the already empirically rare occurrence of force – between police and persons in crisis.