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Police Roll Call Series

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Intersection Accident

Incident Details

An Officer who was operating a marked Ford sedan police interceptor pursuit vehicle (PPV) responded as the fourth car to a reported fight. His emergency lights and sirens were activated as he traveled westbound to the dispatched location. The posted speed limit in the area was 30 mph. The witness statements are consistent in reporting that the officer had a red traffic signal as he entered the intersection and that the police cruiser had its emergency lights and sirens activated. One of the witnesses indicates that the cruiser was moving very fast.

It was determined through examination of the physical evidence that the approximate speed of the police cruiser was 67 mph. The civilian vehicle was traveling at about 19 mph, and any braking only occurred after the vehicles entered the intersection, fractions of a second before impact.

Risk Analysis

Evidence and statements indicate that the Officer did not slow in response to the red traffic light to safely clear the intersection and **in failing to do so was the cause of this collision**.

Liability

There were six occupants in the civilian vehicle. Each of the occupants suffered injuries ranging from minor to serious, including fractures requiring surgical repair. Because the Officer did not continue to drive with the safety and due regard of others and endangered life and property, the liability rests with the Officer and the department.

Lessons Learned

Although Connecticut General Statute (CGS) 14-283 provides discretion on how an officer proceeds through an intersection, it clearly states that officers must continue to drive with safety and due regard for the safety of others.

- Sec. 14-283. (b) The operator of any emergency vehicle may (1) park or stand such vehicle, irrespective of the provisions of this chapter, (2) proceed past any red light or stop signal or stop sign, but only after slowing down or stopping to the extent necessary for the safe operation of such vehicle, (3) exceed the posted speed limits or other speed limits imposed by or pursuant to section 14-218a or 14-219 **as long as such operator does not endanger life or property by so doing**,...

Recommended Changes

Evidence and statements indicate that the Officer did not slow his response to the red traffic light to safely clear the intersection to the extent necessary to proceed safely and **in failing to do so was the cause of this collision**.

- COME TO A COMPLETE STOP AT ALL INTERSECTIONS.
- Do not exceed the posted speed limit. Exceeding the posted speed limit only reduces response time on average by 20 seconds.

Pursuit Accident

Incident Details

A Patrol Officer was pursuing a vehicle to apprehend the driver, who was wanted for a misdemeanor warrant. The weather conditions were poor and the street surface was covered by snow and ice. The suspect vehicle crossed a main artery, with the officer close behind. The suspect made it through the intersection; however, the Officer's vehicle was struck and run over by a semi-truck and trailer. The officer's car was crushed. Fortunately, the officer was able to move within the car to avoid being injured.

Risk Analysis

The Officer failed to stop at a stop sign, slid into an intersection, and his car was struck and crushed by a large truck. The suspect was not apprehended. The pursuit and collision potentially put the community and other Officers at risk.

Liability

State of Connecticut Police Officers must adhere to the Connecticut Uniform Pursuit Policy which clearly outlines when a pursuit is warranted. The officer engaged in a pursuit for a misdemeanor warrant during in climate weather and failed to maintain his vehicle in accordance with 14-218(a) and 14-283- continue to drive with the safety and due regard of others and endangered life and property in doing. In this case liability would rest with the officer and the department.

Sec. 14-283a-4. **Procedures (a) Initiation of Pursuit**. (1) The decision to initiate a pursuit shall be based on the pursuing Police Officer's conclusion that the immediate danger to the Police Officer and the public created by the pursuit is less than the immediate or potential danger to the public should the occupants of such vehicle remain at large. (2) In deciding whether to initiate a pursuit, the Police Officer shall take the following factors into consideration:

A. Road, weather and environmental conditions;

B. Population density and vehicular and pedestrian traffic;

C. Whether the identity of the occupants is known and immediate apprehension is not necessary to protect the public or police officers and apprehension at a later time is feasible.

Lessons Learned

The Officer should have conducted a risk assessment regarding immediate apprehension versus the danger caused by pursuing.

Changes as a Result of that Experience

Police Officers should continuously review the pursuit policies of the State and their own Department. Pursuits for minor offenses are not advised. In this case the subject's identity was known; therefore it would be possible to plan and apprehend them at a later date.

Suspect Searches

Incident Details

A suspect was arrested after a foot chase for shooting a deputy. He was arrested by one of the many different agencies involved in the incident. The arresting Officer made a cursory search and placed him in his patrol vehicle; subsequently transporting him to the local Police Department where custody was transferred to the lead investigating agency. The receiving agency did not search the suspect upon accepting him into the processing area. He could have killed several individuals and Officers during the fingerprinting and photo process. The suspect was cooperative during the intake processing and was subsequently placed into one of the holding cells; again, he was not searched. While in the holding cell the suspect committed suicide by shooting himself in head. It was determined through review of the cell closed circuit television (CCTV) that the suspect pulled from his waist band a firearm once he was inside the cell.

Risk Analysis

The suspect had a fully-loaded and operational .45 caliber automatic handgun concealed in the front waistband of his pants during the interview. He was walked around an office fully staffed by sworn and civilian personnel, creating the opportunity for potential death of both Officers and civilians.

Officer Safety

During the transfer of the suspect neither department who maintained control of the suspect completed a proper search of the suspect which created a significant officer safety concern.

Lessons Learned

Law enforcement agencies should have in place protocols and procedures for the transfer or receiving suspects to or from another agency. These procedures should be regularly communicated to officers within the agency and to outside agencies with whom the department interacts with on a regular basis

Recommendation

With the compact size of weapons and the easy ability to conceal these weapons, Connecticut Police Departments should implement a standard operating procedure in line with the **Connecticut POST-C Accreditation Standard 1.3.17**. The Standard is a written directive that establishes procedures for searching detainees and accounting for each detainee's property before entry to the holding facility.

Unlawful Seizure/Detention

Background

An Officer seized and transported a person without legal justification. The officer self-initiated contact with a subject who was thought to be a suspect in recent breaking and entering incidents.

Scenario

The Officer, who was assigned to the investigation of a motor vehicle collision with injuries, noticed a subject walking by the location who resembled a person of interest in a recent string of burglaries. This individual was not part of the motor vehicle collision investigation. The Officer left the accident scene on foot and caught up to the individual approximately three blocks away. He identified himself to the subject and began questioning him. The individual had not interfered with the Officer's investigation of the motor vehicle collision nor did he provide any reasonable suspicion for the Officer to believe he was a threat to the scene, civilians, or officer safety.

The subject provided identification that showed the individual was not the person of interest; however the Officer questioned the validity of the identification based on the physical similarities between the individual and the person of interest. The Officer did not utilize all reasonable expected methods to further confirm that this individual was indeed the person of interest.

The Officer made a decision, despite being unsure and the identification that indicated the individual was not the person of interest, to take him into custody. He placed him in handcuffs and into the back of the car. During the suspect intake and process at the police department, it was determined that the person who had been detained was not the person of interest for the burglaries and was subsequently released from custody.

Outcome of the Response Activity

An unlawful detention was made of a subject who was not the person of interest.

Explanation of the Contributing Factors

The Officer was not aware of the correct action to take in an incident such as this. The person of interest did not agree to accompany the Officer to the station and was placed in handcuffs as if arrested. The Supervisor in this instance agreed with the Officer's actions indicating that he too did not know the proper procedure.

Lessons Learned

Search and seizure is a very critical part of the routine work performed by sworn law enforcement Officers. It is critical that they understand when they can and when they cannot affect an arrest or restrict a person's freedom. It became readily apparent that the Supervisor in this incident also did not know the proper application of law and/or policy.

Changes as a Result of the Experience

Although the proper procedure was not known by the Officer or the Supervisor, there was no change needed in the department's policy and/or practice. The recommended changes were in the training that instructs officers that they may not stop persons without reasonable suspicion. Much more important is the lesson that if officers have questionable probable cause, they should attempt to take reasonable steps to verify whether or not the suspect is the person wanted before transporting the suspect to the station.

Comments to the Community

Background

An Officer was in a parking lot writing his report of a previous incident that occurred at a flooded underpass. A resident approached the officer and indicated that another person was in distress and stuck at the same flooded underpass. The officer stated "…I will get to her when I finish my paperwork…" The individual then drowned in her vehicle.

Scenario

On August 27, 2006, the local Police Department received calls for assistance at 10:45 PM, and dispatched an Officer to the area of the underpass to assist a vehicle that was stuck in high water. This particular underpass had a history of flooding during heavy rain. The Officer arrived at 10:50 PM where he found a car stalled under the bridge because of the flood water. Per the Police Officer, the water appeared to be around six feet deep. The Police Officer called dispatch and requested another car to the location.

The Officer then put the group of people in his car to drive them around to the other side of the bridge to a safe location to meet a friend who was going to drive them home. The Police Officer did not put out any traffic cones and left the scene prior to the arrival of the other officer. While driving to the other side of the bridge, the Police Officer had to take several detours due to the side roads' flooding. There was flooding all over the city at this time due to heavy rains.

The Officer delivered the individuals to a school parking lot, which is up the street from the south side of the bridge/ flooded area. Once the individuals left the scene, the Officer began to write his incident report. While writing his report the officer was advised by a resident that another car had driven into the water, and a person was trapped. The Officer stated to the resident:

"I will get to her when I finish my paperwork in 5 minutes".

The resident testified that the officer made the statement in a sarcastic manner and seemed not to care. The officer did not contact Dispatch to determine the proximity of the second car he initially requested or to inform them of the second victim.

On the way back to the underpass to check on the vehicle, the resident called 911. By the time the Officer responded, the Fire Department was on the scene and had already pulled the victim from the submerged vehicle. Despite resuscitation efforts the victim died; the cause of death was ruled to be a drowning.

Outcome of the Response Activity

The person was trapped in the vehicle and drowned as a result.

Explanation of the Contributing Factors

Although the Officer called for an additional unit, he did not secure the scene to ensure the safety of other motorists. He did not put out cones and did not wait for the other officer to arrive. Additionally, the statement made by the officer was interpreted as indifference by the jury and portrayed the officer as uncaring.

Lessons Learned

Speaking with the community is an essential function of a Police Officer's duties. Although the Officer was prioritizing his tasks based on his prior knowledge of the scene where the vehicle occupants were able to escape, the officer's communication style was viewed, in this instance, as indifferent. This perceived indifference had a large impact on the jury, leading to a multi-million dollar verdict against the Police Department. It is recommended that Officers receive regular communication training to understand the proper way to address and respond to the community's residents in a manner that conveys professionalism.

Suspect Supervision

Background

Officers detained an Emotionally Disturbed Person with handcuffs, placed him on a kitchen chair, and left him unattended for several minutes without monitoring. The individual slipped his handcuffs and began to fight with the officers, resulting in multiple Taser deployments. The person became unresponsive and died.

Scenario

On May 24th, 2010 at approximately 7:50 PM a local Police Department received a call asking for an officer to respond to a large male who was out of control. Three Officers were dispatched and responded. Upon arrival they found the Emotionally Disturbed Person (EDP) in the bedroom underneath the bed in an uncontrolled rage. He was actively destroying the bed frame, box spring and mattress. Based on these actions, and information provided by the EDP's wife, responding officers determined that this person was in need of a medical/psychological evaluation. One Officer began the Police Emergency Examination Request (PEER) and called for an ambulance to transport the individual to the emergency room. The other two Officers were able to verbally calm the individual down.

At some point prior to the ambulance arriving, the individual became enraged again and threw the destroyed bed across the room and charged aggressively towards the three Police Officers. The Officers again attempted to verbally calm the individual. When this failed to be effective, the Officers escalated the verbal commands and ordered the individual to the ground and to get on his stomach, which he refused. This refusal required the Officers to physically gain control of the individual and placed him in hand-cuffs. Because of his size, the Officers used three sets of hand-cuffs interlocked, securing his hands behind his back. Once they were able to secure the hand-cuffs and gain control of him, the Officers placed him onto a chair in the kitchen.

At this time all three Officers left the individual unattended and turned their backs to him while they spoke to the individual's wife. At this time, the individual was able to "slip" his cuffs and began to fight with the Officers, causing the Officers to deploy multiple uses of force, including the Police K-9 and Taser. The individual was subsequently Tased 35 times. During the altercation the suspect became unresponsive and subsequently died.

Outcome of the Response Activity

This large individual was able to "slip" his hand-cuffs, thus creating a situation which resulting in injury to the Officers, the Police K-9 and his ultimate death.

Explanation of the Contributing Factors

The Officers did not properly monitor the individual which lead to the individual's ability to "slip" his hand-cuffs. This action lead to an increased use of force with the deployment of the Police K-9, a physical altercation, and 35 Taser Deployments.

Lessons Learned

Dealing with suspects, including Emotionally Disturbed Individuals (EDPs), has become one of the most common calls for service law enforcement agencies. These individuals can become out of control very quickly, leading to Officer injury and the individual's injury – sometimes involving fatalities. We learned from this call that the individual was not properly supervised while he was sitting in the kitchen chair. This allowed the individual to "slip" his hand-cuffs. Upon investigation it was determined that this particular Police Department did not train its Officers on the Department's Standard Operating Procedure (SOP) for suspect/EDP supervision. If the individual was properly supervised he would not been allowed to "slip" his hand-cuffs, thus eliminating the need for the increased use of force.

Changes as a Result of the Experience

Although the proper procedure was not known by the Officers, the department's policy and procedures were adequate. The recommendation would be ongoing and regular communication of the department's SOPs, policies and training, especially involving emotionally disturbed individuals. More importantly, Officers must understand that although a person is hand-cuffed they still pose a potential danger and threat to themselves and their fellow officers.

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Questions? Ask your Supervisor or CIRMA Risk Management Consultant.

Work Zone Safety

Background

A police officer who was working an extra-duty road construction job was struck and killed by a small SUV traveling in the work-zone.

Scenario

There were two (2) Police Officers assigned to work an overtime/extra-duty assignment for a town road paving project. The project involved a two lane road being reduced to one. It was near the end of the shift, late in the day, at dusk. It was dark enough to restrict vision, but not dark enough for the street lights to be activated or to require the use of head lights. A light rain had been falling since noon and most cars had their headlights on.

One officer was positioned at each end of the work zone, and both were equipped with portable radio communications. The officers were assigned to control the traffic flow through the work-zone. This was accomplished throughout the shift by one officer stopping traffic to allow for safe passage of vehicles from the other side, and then alternating. The officers would communicate to each other via the portable radios as to when to stop traffic or allow traffic to proceed through.

At 6:00 pm, a small SUV was signaled by the officer on the north side of the work zone to proceed through. Unfortunately, the northbound officer did not communicate to the southbound officer that the SUV was entering the lane. The northbound officer later explained that he looked down the roadway and did not see the second officer or any traffic waiting, so he thought it was safe for the SUV to proceed. The northbound officer further explained that he thought the second officer was in his personal vehicle getting ready to leave.

The southbound officer was struck by the SUV vehicle, when he stepped into the open lane. The officer was thrown to the ground, striking his head and, although EMS arrived shortly thereafter and transported him to a trauma center, the officer unfortunately succumbed to his injuries.

Lessons Learned

- It was determined that the injured police officer was not wearing any high visibility clothing or reflective vests as required by the Department of Transportation.
- Additionally, proper communication between officers did not take place for safe passing of traffic through the work-zone.

Officer Safety Risk Management

Wear the proper ANSI Class High Visibility/Reflective clothing and vests, as required by the Department of Transportation, when working in roadways.

Ensure that proper communication is made throughout the dynamic work-zone at all times. Constant communication, even when it appears your partner is not in harm's way, will ensure that each officer completes the assignment safely.

Wear Protective Vests

Background

A police officer who was shot while responding to a report of two men in an altercation outside of a hotel survived. Police investigators credit the officer's bulletproof vest with saving his life.

Scenario

Police received a 911 call from a person who was witnessing two men physically assault each other at a local gasoline station. After several minutes of fighting, one of the individuals ran to his vehicle and sped off. The second individual got into his vehicle and began following the first individual. The 911 caller got into his car and followed them, while remaining on the phone with the 911 dispatcher the entire time. The 911 caller followed the two men to an area hotel parking lot, where the individuals exited their vehicles and began to engage in a verbal altercation.

Questioned by the dispatcher, the 911 caller was unable to either confirm or deny whether the individuals possessed any weaponry. As a result, the 911 operator dispatched two police offers to the hotel to investigate the situation.

When the first police officer arrived on scene, he exited his vehicle and immediately ordered the two men on the ground. A second police officer then arrived on the scene. At this point, one of the two men pulled out a .38 caliber firearm and fired two rounds at one of the officers, one of which struck the officer in the upper chest area. The second officer immediately returned fire, fatally shooting the suspect. The other suspect was taken into custody.

The police officer who sustained the gunshot to his chest was airlifted to a local trauma center. A short time later, the wounded police officer was alert and conscious.

The Chief of Police issued the statement that the officer was struck once in the chest, over the heart, and because he was wearing his protective vest, he was conscious and alert and was expected to make a full recovery.

Lessons Learned

- The protective vest saved the officer's life.
- Because every situation an officer enters can lead be threatening, protective vests or body armor should be worn on a regular basis. Since 1987, protective vests have saved over 3,100 Police Officers throughout the United States.
- OSHA has also issued an opinion that based on the dangers associated with being a police officer, they will now consider protective vests as required Personal Protective Equipment (PPE).

Officer Safety Risk Management

Wear your protective vest / body armor as you would any other tool on your duty belt.

Police Pursuit

Background

This claim involved a police pursuit and two municipal police departments:

- The evading party was driving a 2001 BMW SUV owned by another party when he failed to stop at a stop sign.
- An officer attempted to stop the BMW for the traffic violation when the driver decided not to stop. The officer then activated his lights and sirens and called into dispatch that he was in pursuit of a BMW that failed to stop at a stop sign.
- Shortly thereafter, a police sargent from the same town joined the pursuit, near an intersection of a major roadway. The pursuit extended into a bordering town.
- A second police officer from the same town entered as the #3 car in the pursuit.
- The bordering town did not provide any resources and did not engage in the pursuit, since the reason for the pursuit was a minor motor vehicle infraction.
- The BMW driver subsequently failed to make a left turn and struck a tenant-occupied house, crashing through the first floor of the structure and striking the injured the claimant while he slept in bed.
- The BMW driver fled the scene but was subsequently arrested.
- The pursuit lasted approximately thirteen (13) minutes in duration.
- The claimant was found pinned under the vehicle, where he remained for approximately 90 minutes while the fire department performed emergency extrication procedures.
- Per affidavit, the BMW operator had permission use to drive the vehicle but it carried no liability coverage.

At-Fault Party Investigation

- The BMW operator was at fault for the crash, which violated C.G.S. 14-223(b) Engaging in Pursuit; 14-222 Reckless Driving; 53a-49 Criminal Attempt to Commit Assault on a Police Officer; 53a-167 Interfering; and 14-301 Failure to Obey a Stop Sign.
- The BMW operator was held in lieu of a $1M bond.
- The BMW driver had an extensive criminal record, having been previously arrested approximately 17 times since 1996.

Pursuing Police Department Investigation

The State Police conducted the investigation and completed the police report with the following findings:

The pursuing police department

- Officer 1 – Per the department's Standard Operating Order 4.07, was found negligent - for failure to comply with any lawful orders, general orders, and directives, either oral or written.
- Sgt. 1 – Per the department's Standard Operating Order 4.01, was found negligent - for failure to properly supervise subordinates and take appropriate disciplinary action. Per 4.07, negligent for failure to comply with any lawful orders, general orders, and directives – either oral or written.
- Dispatcher 1 – Per the department's Standard Operating Order 4.07, was found negligent - for failure to comply with any lawful orders, general orders, and directives – either oral or written.
- Officer 2 – No violation of policy found. His role as a back-up unit to Officer 1 was determined to have been a necessity and not a violation of the department's pursuit policy.

Bordering Town Police Department

•No units pursued the vehicle after discovering the pursuit stemmed from a motor vehicle violation.

Damages/Injury

Claimant suffered second and third degree burns to his lower back, buttocks, and right thigh. He also sustained soft tissues injuries to multiple body parts, including a minimally displaced nasal bone fracture. The claimant subsequently underwent extensive skin grafting procedures on various areas, leaving him with permanent scarring. He lost approximately three months from work while recuperating from his injuries.

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CIRMA Liability Assessment

The BMW operator bears responsibility for this injury as does the pursuing police department for violating their pursuit policy. Without any other appropriate insurance coverage, the pursuing town's police department bears negligence as Joint and Several Liability (JSL) applies. Additionally, neither the injured claimant nor property owner bear any responsibility for this incident. Liability was assessed at 40% to the pursuing town and 60% to the BMW driver.

Unfortunately, the presiding court venue would have potentially contained a jury pool that generally awards verdicts which are similar to those awarded by juries for similar cases in other districts, so settlement was entertained.

Outcome

The case was successfully settled prior to trial for $575,000.

Key Points

The police department should continue to conduct ongoing police training relative to their specific pursuit policies, which should be regularly enforced at basic and recertification training programs. Additionally, the police departments should continue to provide defensive driver training for their officers.

For more information, please contact George Tammaro, Risk Management Services Manager at CIRMA, (203) 946-3700 or gtammaro@ccm-ct.org.

Holding Cell Supervision

Background

The decedent had been arrested after becoming belligerent and violent while being treated at a local hospital. A doctor's report noted that the individual displayed signs of emotional distress, information which was not communicated to the arresting officer. After the formal arrest and intake, the decedent was placed in a holding cell fully clothed and still holding his hospital gown. The police department had a formal policy stating that prisoners would be checked at least every 30 minutes and a mental health (suicide) screening to be completed as part of the intake process.

Scenario

After approximately 25 minutes in the holding cell, the decedent began to act erratically — climbing on the sink, covering the in-cell CCTV, and crying uncontrollably. Fifteen minutes later, while still crying, the individual tied his hospital gown around the cell doors and removed his sweatshirt. Five minutes later, the decedent looked directly into the cell's camera and tied the sweatshirt around his neck. He then attempted to secure himself to the top cross bar, which was above his reach. He then tied his sweatshirt to the second highest cross bar, then dropped his weight, causing the sweatshirt to stretch and release. After five additional minutes, he once again tied the sweatshirt around his neck and this time he successfully climbed to the top cross bar of the cell doors and secured his sweatshirt. He dropped his weight again and hanged himself. Police officers arrived and unfortunately, they had difficulty in opening the cell doors because of the tied hospital gown and sweatshirt, causing additional delay in cell entry and rescue. Once the officers gained access, they successfully cut the sweatshirt to free him, and performed CPR until Fire and EMS personnel arrived. The decedent was transported to the hospital where he died from his injuries.

Lessons Learned

The incident might have been prevented with regular training on SOPs regarding detainee assessment, intake, and supervision. Specifically:

- The decedent was placed in cell with several non-essential items.
- The required 30-minute cell checks were not performed.

Recommended Best Practices

CIRMA suggests the following:

- Police departments should review their prisoner supervision, assessment, and intake policies.
- Police departments should implement policies that require both routine time-based prisoner checks and more frequent time-based checks for high-risk prisoners.
- Police departments should train all dispatchers, desk officers, and any other personnel who have the responsibility for prisoner supervision on the departmental policies that address audio/visual equipment used in prisoner detention and lock-up facilities.
- Police departments should document their supervision efforts to record when the cell checks are completed.
- Police departments should implement a policy prohibiting non-essential items in holding cells, thus limiting the use of cutlery, drink containers, and loose fabric or clothing that could be used to harm the detainee or officers.
- Police departments should document mental health screenings in accordance with their SOPs.
- Police departments should ensure that routine maintenance inspections include prisoner detention and lock-up facilities.
- Police departments should consider safe location areas in or near prisoner detention and lock-up facilities to house tools or devices to perform emergency entry into cells.

Domestic Violence Liability

Background

Between 4:30 and 5:00 PM on November 14, the victim was stabbed multiple times by her estranged husband. At the time of the attack, the victim and her husband were in the process of a very contentious divorce. A protective order against the husband had been issued 30 days before the attack for an earlier harassment and disorderly conduct incident.

Scenario

Before the protective order was issued, the victim's husband had been harassing her by contacting her over 50 times a day – leaving voice mail messages and sending text messages. The estranged husband used a knife to puncture the victim's vehicle tires. The victim's attorney advised her to file a complaint with the local police department, which she did.

After taking the victim's statement for the protective order, and making copies of the voice mails and text messages, the officer informed her that he would contact her husband to obtain his version of what happened. The officer reviewed the protective order which was one of "no contact." His interpretation of the protective order was that it prohibited the husband from imposing any restraint, threats, harassments, or entering the family dwelling. The officer stated in his deposition that he did not ask whether the victim was afraid of her husband or thought that he would hurt her. After the victim left the police station, the officer made telephone contact with the husband and explained that his wife had filed a complaint against him, alleging harassment. The officer requested that the husband meet with him at the station to discuss the complaint, at which point the husband became agitated and made several off-color comments and refused to come down to the station. He commented,"Can't wait for her to see what will happen when I get out of prison," then hung up the phone. No further action was taken by the police department at that time.

On the day of the stabbing, the victim arrived home and was backing into her assigned parking space, when she noticed her husband waiting for her. The victim's husband began yelling and screaming at her for contacting the police. She immediately picked up her cell phone to call the police, at which point the husband smashed open her driver's side window, pulled out a large knife and began stabbing her. The victim managed to escape and ran inside her home. Her husband followed close behind and managed to force himself inside the dwelling. Once inside, victim's husband began violently attacking the victim's elderly mother, all the while continuing his assault on the victim, stabbing her several more times in the back and arms. The victim's son witnessed what was occurring and called 911. When police arrived on scene, the husband was sitting on the grass outside the dwelling in a daze. He was handcuffed and taken into custody without incident and charged with attempted murder. The responding officers administered first aid to the victim and her mother. Both were transported to the hospital and treated for serious injuries.

Lessons Learned

- The officer taking the report did not follow the Lethality Assessment Protocol (LAP) or any SOP.
- The officer failed to create a either a short or long term safety plan.
- The officer's interpretation of the protective order was questionable, at best.
- There was no action taken by the police department based on the husband's aggressive and off-color comments.

Recommended Best Practices

CIRMA recommends the following best practices:

- Police departments should review their Family and Domestic Violence Policy on a regular basis with command staff, officers, and dispatchers.
- Police departments should train all dispatchers, desk officers, and any other personnel who have responsibility for following policies and protocols associated with LAP.
- Police departments should consider conducting regular training on the key components of establishing a short and long term safety plan for victims and document their efforts.

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Questions? Ask your Supervisor or CIRMA Risk Management Consultant.

Preventing K-9 Self Deployments

Background

The canine officer arrived at the scene of a physical assault, where three suspects quickly adhered to the officer's commands to stop fighting. The officer began interviewing one of the suspects, but moved out his K-9's sight, prompting the K-9 to self-deploy and bite the suspect. This happened a second time before the officer secured the K-9 in the back of his police vehicle.

Scenario

When the canine officer arrived at the scene, he observed three women in a physical altercation on the sidewalk adjacent to a busy four-way intersection. The officer exited the vehicle, leaving his driver's side door window open, in the event he required the K-9's assistance. The women complied with the officer's commands to stop fighting and got onto the ground in a prone position, allowing the officer to safely separate and secure them. Upon arrival of police back up, the interview process began. The officer escorted one of the females around the corner – out of the K-9's sight, which triggered the K-9 to self-deploy from the open driver's side window and bite the female on her upper leg. After several "break" commands, the K-9 released his hold and returned to the vehicle per the direction of his handler. The woman, who was bitten, was crying uncontrollably, requiring the officer to raise his voice to get her attention. As a result, the K-9 perceived the shouting to be threatening to the handler and self-deployed a second time, biting the woman in the arm while she was trying to protect herself. After several more break commands, the K-9 released and the officer secured the K-9 in the back of his police vehicle to prevent it from deploying a third time.

Lessons Learned

- The officer did not follow training protocols and conducted his interview out of his K-9's sight, causing the dog to self-deploy as he was trained.
- The officer did not follow training procedures that dictate to keep "One eye on the suspect and one eye on the K-9" at all times.
- When the K-9 self-deployed the first time, the officer should have assessed why the K-9 self-deployed and adjusted his interview location and interaction with the woman.
- The officer should have secured his dog in his vehicle to prevent a second self-deployment.
- Door popping hardware / setups may have prevented this incident from occurring.

Recommended Best Practices

Recommendations and best practices are as follows:

- Continue regular and ongoing training for both the handler and K-9 on deployment methods which may include:
    - Deployment from vehicle training.
    - Health and obedience.
    - Legal liability, and
    - Report writing.
- Continuous training of the handler on situational awareness and scene safety for themselves, the K-9, and interviewee.
- Consider outfitting all K-9 vehicles with "Door Popper," a device that eliminates self-deployment because the K-9 cannot deploy until the officer presses a release button on his or her uniform, and training handlers on its proper use.

Special Note

Because not all departments have upgraded their fleets, which now come prefabricated with the K-9 vehicle patrol set ups, there may be older vehicles still in use that do not have door-release hardware. Regular ongoing training should be continued with the handler and K-9 on obedience, situational awareness, and safety considerations for the officer and K-9.

Officer Involved Shooting

Incident Details

The claimant is a retired police officer and military veteran. Subsequent investigation into the claimant's background indicates that he was being treated for PTSD and had a valid firearm carry permit in the State of Connecticut.

The claimant's wife located various computer storage cards in claimant's duffle bag. During her review of the files of the computer storage cards, the wife located a video of her and her husband's nude fourteen-year-old daughter. The video depicted the claimant's daughter in sexually provocative positions.

The wife transported the duffle bag and its contents to a family member's house and contacted the local police department, prompting an investigation by the department. In the course of this investigation, the local police department secured a search warrant for claimant's residence. The search of his home led to the discovery of child pornography, such as a video of claimant's naked fourteen-year-old daughter and other items, all of which were seized. Based on the videos discovered by the wife and her sworn written statement, a felony warrant for the arrest of the claimant was applied for and issued. Between the time claimant became aware of the arrest warrant and his arrest, he sent his wife numerous text messages, which she perceived as indicating an intent to harm himself and resist arrest.

The Defendant Police Department received a call from the warrant-issuing Police Department requesting its assistance in locating and apprehending claimant. The "Issuing Police Department" informed the Defendant Department that the claimant was in their town at a local movie theater – his location was known by tracking his mobile phone, which indicated his last known location. The Issuing Department also informed the Defendant Department:

"…that the claimant was determined to harm himself and would take someone out with him…"

Other than this statement by the claimant, which was communicated to the Issuing Department by his wife who was filing for divorce, there were no other indications that the individual was violent or would resist arrest.

The Defendant Police Department dispatched two officers to the "last known location" and found the claimant's vehicle in the theater's rear parking lot. This was further confirmed by the Defendant Department "running" the vehicles registration and it coming back to the claimant as the registered owner. It was then determined by these officers that the claimant was inside the theater watching a movie.

At this time the officers contacted the on duty Sergeant and a plan to apprehend the claimant was formulated. This plan included additional resources from the department and the Issuing Department. The plan was essentially to "box in the claimant" and take him into custody as he approached his vehicle. The area where the vehicle was parked has low light and is away from the main entry.

At 2:00 a.m., the claimant was observed exiting the theater and proceeding to his vehicle where he was observed unlocking his vehicle with a remote key fob: a small black object. At this time, two officers from the Defendant Department began to run up behind the claimant with their firearms in the "low ready" position. They identified themselves as police and commanded the claimant to get down. The claimant, hearing the movement and commands, turned around and faced the officers. The officers state that this is when the claimant reached into his waistband area as if he was retrieving a firearm, causing both officers to discharge their weapons:

- A total of ten shots were fired – five from each of the Defendant Department's officers involved.
- The claimant was struck in the left foot.
- Two other police officers on scene were injured: one sustained a gunshot wound to the forearm and the other sustained shrapnel injuries.
  - This was the result of the apprehension plan positioning, which put the officers at risk of injury from "cross-fire."

The claimant was taken into custody and transported to a local hospital for treatment where it was determined that he sustained a single gunshot wound to his left foot, causing:

- Comminuted fractures of the metatarsals;
- Status post wound debridement and removal of bullet fragment; and
- Residual shrapnel in the left foot.

The claimant was treated and released by the hospital and taken into custody. The claimant pleaded guilty to felony risk of injury to a child and was sentenced to five years in prison, execution suspended after twenty-one months.

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Investigation and Damages/Injury

The claimant continues to complain of pain in his left foot, numbness, and a feeling of having a drop-foot. His doctor has assigned a 23% impairment rating for loss of function of the foot and ankle.

Medical specials are $30,341. The claimant also alleges loss of wages of $64,000; however, since he was incarcerated shortly after this event for the child pornography charges, this wage loss is not supported. Furthermore, there is a State lien to recoup the cost of his imprisonment in the amount of $77,947 for his incarceration so he was obligated to pay the lien or 50% of any recovery he obtained in this case.

CIRMA Liability Assessment

Liability was viewed as problematic for the Defendant Department in several areas.

According to the officers, the verbal plan was developed by the on-duty Sergeant whose subsequent suicide precludes any ability to question his process for implementing the arrest plan. However, the plan was described by the patrol officers on scene to be aggressive, as evidenced by officers approaching the plaintiff from behind, in the dark, yelling at the plaintiff with guns drawn.

- There were no allegations in the warrant or by the Issuing Department that the plaintiff was carrying a weapon or was considered dangerous other than the statement from the wife.
- The plan further placed other officers in a cross-fire situation, as evidenced by the other two officers who sustained gunshot and shrapnel injuries.
- The number of shots fired could be considered excessive.

The claimant alleges that he heard yelling as he was walking to his vehicle with his hands by his sides, turned around and saw two people approaching him with guns drawn and yelling at him. The claimant states that, when he saw the guns pointed at him, he raised his hands in the surrender position. He states that he still had his key fob in his hands. The claimant denies that he reached into his waistband, denies that he pointed anything toward the police, and denies that he was trying to commit "suicide by cop."

While the claimant, who is a convicted sex offender, wouldn't have made a likable witness for himself, he is educated and articulate. He was not armed when the incident occurred and the numerous questions of fact in this case survived summary judgment.

Because of the adverse climate with regard to law enforcement officer involved shooting (OIS) cases, combined with the questions of fact, it was decided to reach a settlement with the claimant.

Key Recommendations/Action Items

Based on the facts outlined in this scenario, the below recommendations are being offered for consideration to reduce potential officer injuries and liability planning the apprehension of an unknown violent/non-violent suspect wanted on a felony warrant in a publicly located area with multiple risk factors.

- Complete the warrant risk analysis prior to serving the felony warrant in a public location. Based on the point value, determine if a public location is the appropriate place to execute the warrant.
- Utilize body-worn camera technology, video camera, or CCTV to record the tactical actions utilized. This will provide a record that can be used in defense of any potential liability claims.
- Review the apprehension plan to ensure that positioning of officers reduces the likelihood of cross-fire injuries.
- Consider the use of less lethal ammunition, if available.
- Consider the use of an Emergency Response Team.
- Obtain a copy of the text messages and include them in the officer's report.
- Consider conducting "apprehension" planning training to Supervisor's and officers as an elective for recertification.
- Conduct an agency After Action Report (AAR) to identify additional training and planning needs.