Public Report

June 26, 2018: In-Custody Death

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INCIDENT

Much of this incident was recorded on a body-worn camera worn by an officer involved. In keeping with Supreme Court precedent which states that uses of force must be judged based on what the officers knew (or reasonably believed) at the time force was used, and not with the benefit of 20/20 hindsight,[1] I have endeavored to describe the incident based on interviews describing the officers' states of mind during the incident. I have reviewed the body-worn camera footage, and it is consistent with the officers' accounts of what transpired.

On June 26, 2018, Fairfax County Police Department (hereinafter "FCPD") officers from both the Franconia and the Mount Vernon District Stations were dispatched to a residence on Mission Court, in the Alexandria section of Fairfax County, for a suspected drug overdose. The initial call was made to the Department of Public Safety Communications at 4:35 p.m. The caller stated that his brother, an individual identified as having the initials C.P. (hereinafter "CP"), was at the residence vomiting, being destructive, and possibly under the influence of a narcotic. The caller also advised that his mother was present at the location with his brother. Because of the possible need for medical attention, personnel from the Fairfax County Fire and Rescue Department (hereinafter "FCFRD") also responded to the location.

The first FCPD officer (hereinafter "OFFC#1") arrived on the scene at 4:47 p.m., and within twelve minutes several more officers, including Sergeant #1 (hereinafter "SGT#1"), and FCFRD units had arrived. OFFC#1 obtained information from CP's mother prior to entering the residence with Police Officer First Class #1 (hereinafter "PFC#1"), the second officer to arrive on scene. When they entered they observed CP in an agitated state screaming and grunting, and destroying furniture in the living room of the house. He did not respond when the officers repeatedly attempted to communicate with him in an effort to calm CP down. While not responding to the officers' entreaties, CP acted erratically and threw himself down on a glass table. He continued to thrash his body and to break things in the house. Based on this behavior,

[1] Graham v. Connor, 490 U.S. 386 (1989).

OFFC#1 accessed Oleoresin Capsicum ("OC") spray,[2] and PFC#1 unholstered their electronic control weapon.[3] Ultimately, neither was used.

Shortly after the officers entered and tried to de-escalate the situation, CP fell face down to the floor. When he fell, OFFC#1 and PFC#1 approached to detain him and to handcuff him. Police Officer First Class #2 (hereinafter "PFC#2") and Police Officer First Class #3 (hereinafter "PFC#3") arrived at this time. After being handcuffed, CP was placed in a seated position, but he continued to thrash his legs about. The officers detaining CP requested a Ripp Hobble restraint device[4] so they could secure his legs. After applying the restraint, the officers laid CP on his right side because he was unable, or unwilling, to remain in a seated position due to his medical or mental state. At 4:54 p.m., FCFRD units entered the house when they were advised it was safe for them to do so. Although CP's hands and feet were now secured, he began to bang his head on the marble floor. OFFC#1 took control of CP's head to prevent him from continuing to bang it on the floor. Also, a pillow was placed under his head to prevent him from hurting himself any further. CP then began to spit up.

Both the handcuffs and the Ripp Hobble restraint device were removed so that medical aid could be provided to him. While a medic from FCFRD prepared medicine to administer to CP, they noticed that CP had become lethargic and was no longer thrashing his body. By 5:06 p.m., he had gone into cardiac arrest. FCFRD personnel performed Cardio Pulmonary Resuscitation ("CPR"), and transported CP to Alexandria Hospital at 5:25 p.m. Within minutes of their arrival, the Emergency Room doctor pronounced CP deceased.

CRIMINAL INVESTIGATION/ PROSECUTIVE DECISION

Both a criminal and an administrative investigation were commenced on the date of this incident. The results of the criminal investigation, conducted by the FCPD's Major Crimes Bureau (hereinafter "MCB"), were presented to the Fairfax County Commonwealth's Attorney's Office to determine whether criminal charges would be brought against any of the FCPD officers involved in the incident. In finding that charges were not warranted, Commonwealth's Attorney

[2] Commonly referred to as "pepper spray."
[3] Commonly referred to as a "taser."
[4] A belt-like restraint device often used to prevent an individual from kicking while being transported.

Raymond F. Morrogh reported that "[g]iven the physical findings from the autopsy, the description of events from everyone on scene, along with the video footage captured on [PFC#1]'s body worn camera, there is no evidence that the amount of physical force used in this case was any more than necessary to restrain [CP] from further injuring himself or others. Further, there is no indication that the restraint contributed to his death."[5] This conclusion is consistent with the Office of the Chief Medical Examiner's finding that the cause of CP's death was accidental "Acute Fentanyl Poisoning," and that "there is no indication that the [police] restraint contributed to his death."[6]

The criminal investigation was included in my review of this incident to get a full understanding of the FCPD's overall response. It is my opinion that the FCPD criminal investigation was complete, thorough, objective, impartial, and accurate.

INTERNAL ADMINISTRATIVE INVESTIGATION

An administrative investigation was initiated by FCPD's Internal Affairs Bureau (hereinafter "IAB") on the day of this incident because it involved the death of an individual while in the custody of FCPD officers. The criminal and administrative investigations were conducted separately but simultaneously (parallel), and IAB detectives were part of the initial investigation coordinated by MCB at the scene.

The FCPD's administrative investigation, which incorporated the findings of the criminal investigation, included the review of all Computer Aided Dispatch data and FCPD police radio communications related to the incident; interviews of CP's family members; an interview of a civilian with personal knowledge of CP who was outside of the residence during the incident; interviews of all FCFRD and FCPD personnel who were involved in the incident; an examination of the scene of the incident by the police department's Crime Scene Section; a review of the training records for the FCPD officers involved in the incident; and a review of both the Commonwealth Attorney's and the State Medical Examiner's conclusions.

[5] Report of Investigation, Fairfax County Commonwealth's Attorney Raymond F. Morrogh, dated November 21, 2018.

[6] Office of the Chief Medical Examiner REPORT OF INVESTIGATION and REPORT OF AUTOPSY, both dated August 9, 2018.

The IAB investigation concluded that there had been a violation of the FCPD Standard Operating Procedure (hereinafter "SOP")[7] relating to the use of the Ripp Hobble device used on CP. Otherwise, there were no policy violations noted.

I believe the FCPD administrative investigation into this incident was complete, thorough, objective, impartial, and accurate; and, that the violation of the Ripp Hobble SOP was technical in nature and did not constitute any intentional wrongdoing.

CONCLUSIONS

The force used on CP was minimal, if not inconsequential. In fact, only the use of the Ripp Hobble restraint device constituted a use of force pursuant to FCPD policy. FCPD General Order (hereinafter "G.O.") 540.1 I. G., in defining "Force," explains that "[f]orce does not include escorting or handcuffing an individual who is exhibiting minimal or no resistance;" and, that "[m]erely placing an individual in handcuffs as a restraint in arrest or transport activities, simple presence of officers or patrol dogs, or police issuance of tactical commands does not constitute a reportable action." The handcuffs were put on CP so that he would be unable to engage in destructive or harmful behavior while being transported for treatment, and was clearly a reasonable decision made by OFFC#1 and PFC#1.

When CP continued to thrash his legs after being handcuffed, the Ripp Hobble device was placed on him to secure his legs. This comported with departmental policy which recognizes that the intended purpose for using the Ripp Hobble is to satisfy the "need to provide appropriate methods to *protect persons in custody from injury*, limit the opportunity for escape, as well as limit the risks of injury or bloodborne pathogen exposure to officers and other citizens . . . *when handcuffing alone proves to be inadequate* or to be not practical."[8] The officers' limited use of force in this situation was objectively reasonable, which is the standard required by both FCPD policy and by the relevant laws governing use of force in this country.[9] However, despite the reasonableness of the officers' actions, the administrative investigation into the incident did determine that the department's SOP governing the use of the Ripp Hobble device had been violated.

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[7] FCPD Standard Operating Procedure (hereinafter "SOP") 07-029.
[8] *Id*. (*emphasis added*).
[9] FCPD G.O. 540.0; Graham v. Connor, 490 U.S. 386 (1989); and United States Constitution Amendment IV.

While the Ripp Hobble was used for the proper purpose, not all policy provisions regarding its use were met when CP either could not or would not remain in a seated, upright position. Because he was unable, or unwilling, to remain in a seated position, CP was briefly placed in a lying position on his right side. FCPD SOP 07-029 requires that "[t]he RIPP Hobble will be used according to the manufacturer's instructions," to include keeping the subject in an upright position and not allowing the subject to lie on their side after being restrained by it. Nevertheless, this deviation from the SOP guidance was not malicious in that officers used the device for the wellbeing of CP to keep him from being injured. When he became unresponsive, both the handcuffs and the Ripp Hobble device were removed immediately. Furthermore, the determination of the Office of the Chief Medical Examiner was that "there is no indication that the [police] restraint contributed to [CP's] death."[10]

Finally, it is worth noting that three of the officers involved in this incident had received Crisis Intervention Training; two had received Mental Health Awareness Training; one had received Hostage Negotiator Training; and all six had received training on the proper use of the Ripp Hobble device. Additionally, the officers who responded to this extremely volatile situation comported with departmental policy by attempting to de-escalate the encounter using verbal communications;[11] by being cognizant that CP "may not [have understood] their directions or commands due to underlying medical, cultural, language, mental health issues, or other disabilities;"[12] and by "[taking] appropriate steps to factor these limitations into their critical decision making process."[13]

RECOMMENDATIONS

The SOP violation acknowledged in the investigation into this incident relates to a possible deficiency in the SOP itself: the SOP does not address a situation when an individual refuses, or is unable, to remain in an "upright, seated position,"[14] or will not "lean back against a

[10] *Supra*, note 6.
[11] FCPD G.O. 540.2 I. A. states that "[d]e-escalation is the result of a combination of communication, tact, empathy, instinct, and sound officer safety tactics. The ultimate goal is to help achieve a positive outcome by reducing the need for force."
[12] FCPD G.O. 540.4 I. B.
[13] *Id*.
[14] FCPD SOP 07-029.

firm, fixed object (seat back, tree, wall, etc.) to relieve stress on the diaphragm."[15] This situation may occur as the result of an individual's medical condition or mental state as was the case in the incident under review, or when a subject is actively or aggressively resisting arrest as was the case in a June 2, 2018, incident reviewed by the Independent Police Auditor.[16] Based on a review of and the subsequent investigation into the June 2, 2018 incident, an FCPD commander requested reviews by the Fairfax County Criminal Justice Academy training staff and the FCPD's Director of Accreditation. I agree with the commander's request for reviews of the departmental training on the use of the Ripp Hobble restraint device, and with possibly changing the language contained in SOP 07-029 to recognize limited situations when non-compliance with "manufacturer's instructions" on its use would be permitted.

FCPD policy thoroughly addresses the use of force and provides its officers extensive guidance on the types of force that are typically considered objectively reasonable in different situations. The policies are in direct alignment with Supreme Court precedent. The FCPD analyzed the actions of all officers involved in this incident by examining them against the policies in place, and I believe that these conclusions are sound. Other than agreeing with the reviews of SOP 07-029 and the training associated with the use of the Ripp Hobble device, which has already been initiated by the FCPD, I have no additional recommendations to make based on this incident review.

[15] *Id*.
[16] Office of the Independent Police Auditor Public Report – "June 2, 2018: Use of Force Complaint."