

Police Roll Call Series



Updated June 2022





Table of Contents

Topic Title	Issue
Intersection Accident	1
Pursuit Accident	2
Suspect Searches	3
Unlawful Seizure/Detention	4
Comments to the Community	5
Suspect Supervision.....	6
Work Zone Safety.....	7
Wear Protective Vests.....	8
Police Pursuit.....	9
Holding Cell Supervision.....	10
Domestic Violence Liability	11
Preventing K-9 Self-Deployment.....	12
Officer Involved Shooting	13
Responding to Mental Illness and BWCs	14
Excessive Speed	15
Work Zone Safety for Law Enforcement	16
Dealing with Presumptions of Death	17
De-escalation and Training Breakdowns.....	18
Frequency Breeds Severity.....	19
Search of In-Custody Suspects.....	20
Communicating Vendors' First Amendment Rights at Town-Sponsored Events.....	21
Law Enforcement Liability - Use-of-Force	22
Training Risks	23
Racial Profiling.....	24
Implicit Bias	25
Failure to Train.....	26

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.

Questions? Ask your Supervisor or CIRMA Risk Management Consultant.

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.

Questions? Ask your Supervisor or CIRMA Risk Management Consultant.

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.

Questions? Ask your Supervisor or CIRMA Risk Management Consultant.

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.

Questions? Ask your Supervisor or CIRMA Risk Management Consultant.

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.

Questions? Ask your Supervisor or CIRMA Risk Management Consultant.

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.

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.

Questions? Ask your Supervisor or CIRMA Risk Management Consultant.

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.

Questions? Ask your Supervisor or CIRMA Risk Management Consultant.

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 sergeant 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.

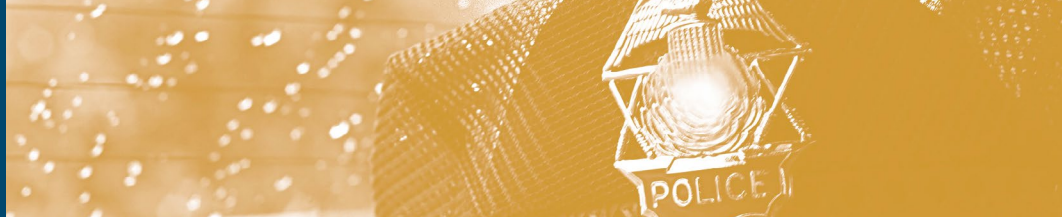
Bordering Town Police Department

- 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

- Continued next page



Cont.

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.

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.

Questions? Ask your Supervisor or CIRMA Risk Management Consultant.

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.

Questions? Ask your Supervisor or CIRMA Risk Management Consultant.

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 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.

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 of 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.

Questions? Ask your Supervisor or CIRMA Risk Management Consultant.

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 vehicle's 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.

- Continued next page

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.

Questions? Ask your Supervisor or CIRMA Risk Management Consultant.

Responding to Mental Illness and BWCs

Incident Details

On June 26 at 0130 hours the central dispatch center was contacted by an alarm-monitoring company regarding a local convenience store, where the burglar alarm was activated and contact could not be established. Per protocol, two uniformed officers were dispatched to the scene.

Officer A was first to arrive on scene at 0133 hours; he observed the front door to be broken with the alarm sounding, at which point he relayed the information back to dispatch and requested a supervisor to be dispatched. Officer A activated his body worn camera (BWC), announced himself, and gave the verbal command that anyone inside the building “To show themselves.” After no response, Officer A entered the store with his firearm in the low ready position. Upon searching the store, he noticed the subject crawling around on his hands and knees muttering gibberish. The suspect did not respond to the officer’s commands, nor did he appear to be aggressive.

At 0136 hours, Officer B arrived on scene, activated his BWC and entered the store. Initial images from Officer B’s BWC showed Officer A on top of the subject who was lying on his stomach with his arms outstretched. Officer A stood up and grabbed the subject’s legs.

At 0139 hours, the supervisor, a sergeant, arrived on scene and observed the following:

- Officers A and B exiting the store with the subject in handcuffs.
- The subject was still muttering gibberish.
- The subject had blood flowing from the side of his head and nose.
- The subject’s shirt was tattered and large red marks on his ribs and back were visible.

The sergeant called for EMS, then began questioning Officers A and B as to what had transpired in the store. EMS arrived at 0147 hours, administered medical care, and transported the subject to the local hospital where he was treated. The hospital identified the subject and contacted his family. The family advised hospital staff and the officers on scene that the subject was currently under the care of a physician for paranoid schizophrenia and recently began taking a new medication regiment. The family stated that the subject had no previous history of violent behavior and often will seek out places to hide whenever he experienced a paranoid episode. The family cooperated and authorized the release of the medical reports which corroborated with the family’s statement.

Police Department Investigation:

As part of the investigation, the sergeant requested to review both Officers A and B’s BWC footage. In doing so, the sergeant discovered that neither of the officers’ BWC’s had captured the entire incident. Officer A’s BWC failed to capture any further recordings beyond the initial contact with the subject. Additionally, Officer B’s BWC footage had stopped after capturing Officer A standing up and grabbing the subject’s legs.

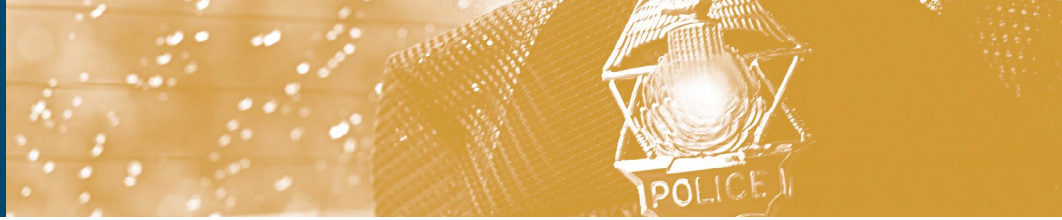
When the sergeant questioned the officers about the failed BWC footage, the officers replied that their buttons may have been pushed during the struggle with the subject.

Officers A and B documented in their respective reports that the subject became violent and was non-compliant with their verbal commands. The sergeant was skeptical of how the events unfolded and immediately referred the case to their internal Department of Professional Standards.

The department’s internal investigators obtained and reviewed surveillance video from inside the convenience store containing footage one hour prior and one hour post incident. The surveillance video showed the following:

- Officer A arriving on scene and entering the facility with his firearm in the low ready position.
- Officer A encountering the subject who is on his stomach and securing his firearm.
- Officer A issuing verbal commands and the subject placing his hands to his sides.
- Officer A approaching the subject, then kneeling and kicking the subject.
- The subject trying to get to his knees while Officer A grabs his ankles.
- Officer B arriving, encountering Officer A and the subject while touching his chest in the area of the BWC, then kicking the subject on the side of the head.
- The subject collapsing to the ground from his knees and stops moving.

- Continued next page



- Officers A and B standing over the subject, placing handcuffs on the subject.
- Both Officers A and B assisting the subject to his feet and exiting the store.

Additionally, during interviews with Officers A and B, Officer A stated that the subject kept repeating that people were following him. Officer A further stated that the subject was not listening to his commands and that he thought the subject was acting “crazy.” When Officer A was questioned why his BWC did not work, Officer A stated that he thought he was dealing with an emotionally disturbed person and did not want to capture the incident on camera. Officer B’s statement was very similar to Officer A’s.

The department’s internal investigators found that there was significant discrepancy between the officers’ statements and the events captured on the convenience store’s surveillance video.

- It was determined by that Officer A and B did not adhere to the department’s BWC policy when he turned off their BWC’s during the incident. Department policy clearly stated that once the BWC was activated it should remain activated unless meeting one of the several situations outlined in Section E of the State of Connecticut Model Policy on BWC’s.
- Although Officers A and B had signed off on the policy, there was records of departmental training during the past two recertification periods.
- Both officers stated they were not formally trained on the policy and were unaware of the policy and procedures.
- The subject sustained a concussion, broken nose, laceration to the left temporal area requiring seven stitches, bruised ribs and back. He was hospitalized for three days and released.
- The subject was charged with breaking and entering, resisting arrest, and interfering with a police officer. With the exception of breaking and entering, all charges were ultimately dropped.
- The subject was granted Accelerated Rehabilitation (AR) and was ordered to make restitution for the broken front door.

Outcome

The subject’s family filed suit against the department alleging excessive force and failure to train. A demand was issued for \$250,000. CIRMA ultimately settled the claim for \$85,000, which included attorney’s fees and medical payments, based on the following:

- Inconsistencies with officers’ statements in comparison to the surveillance video.
- Lack of departmental training records regarding body-worn camera policy and procedures.
- Insufficient training regarding dealing with emotionally disturbed individuals.

CIRMA Recommendations:

- Review the department’s policy regarding Body Worn Cameras and determine if it meets or exceeds the current State of Connecticut model policy, then provide training.
- Provide officer training on dealing with situations involving the use of force.
- Provide officer training and education on identifying signs of mental impairments and procedures for handling subjects with these conditions.

Questions? Ask your Supervisor or CIRMA Risk Management Consultant.

Excessive Speed

Background

On March 31st two police officers were processing evidence at the police department. At 8:30 pm they were dispatched for a call for service, a motor vehicle-pedestrian accident. Based on the nature of the call, they assumed there would be serious injuries. According to the Chief, the dispatched call was a Code 3, lights and siren.

The video shows both officers running out the back door of the police department to the parking lot where their cars were parked. The first officer enters her cruiser and puts on her lights and siren before exiting the parking lot. It appears on video that she is traveling at a fast rate of speed – up to approximately 70 miles per hour. The second officer had previously received a suspension before the incident for engaging in a pursuit, which may have caused him to be more cautious. He entered his cruiser and began to proceed to the scene at a lower rate of speed. Approximately two miles from police station, the first officer entered a red-light controlled intersection at approximately 35 miles per hour and struck a vehicle driven by the claimant.

Seconds before the collision, the Sergeant called out on the radio that the pedestrian was only struck by the mirror of the car. These communications would inform the officers that the nature of the accident was less serious than previously believed. The first officer reached for her radio to ask whether the Sergeant wanted her to speak with the complainant or keep heading to the location where the accident occurred. It is at this moment that she enters the intersection at approximately 35 mph and the accident occurs. What is clear is that she slowed down well prior to entering the intersection.

The claimant in the vehicle was found to be unconscious and unresponsive due to head trauma caused by the accident. Emergency Medical Services (EMS) was called to the scene of the accident and transported the claimant to a local trauma center, where he was treated for bilateral hemorrhagic contusions. He was released from the hospital, and transported to a rehabilitation hospital for brain injuries, speech therapy, and memory deficits. In April, the claimant was released from the rehabilitation facility and continued to receive treatment at home. He continues to have residual effects of the accidents, such as blepharospasm (involuntary eyelid movement /twitching) that his neurologists attributes to the accident. He missed thirteen weeks of work.

Liability Investigation

Part of the investigation focused on the sequencing of the light and the motor vehicle operations of both the claimant and the first officer. Based on the observing the light sequence, it appears that approximately three seconds had elapsed from the time the lights change from green to red. During the three second period, the claimant would have had the yellow light, and may have accelerated to beat the yellow light, which is a violation of Connecticut motor vehicle law. However, there is little question that the responding officer should have stopped or slowed down for the safe operation of the vehicle prior to entering the intersection. Their failure to do this may amount to a violation of CGS 14-283 and department policy.

Outcome

The claimant's initial demand was \$750,000. However, a mediation settlement agreement was reached and subsequently approved for \$350,000.

Recommended Best Practices

Based on the information presented in this scenario, CIRMA Risk Management recommends the following:

- Ongoing training and communication regarding C.G.S. 14-283 for all officers
- Ongoing training and communication of departmental policies and procedures
- Participation in *Defensive Driving Training for Law Enforcement*

Questions? Ask your Supervisor or CIRMA Risk Management Consultant.

Work Zone Safety for Law Enforcement

Incident Details

On the date of the incident, a private construction company, who was doing work on a town road and sidewalk, contacted the local police department in order to hire a Police Officer to be present at the work site between the hours of 8:00 am and 3:30 pm and subsequently executed a contractual agreement. The contractual agreement stipulated that, the officer on scene would have the sole responsibility for traffic control, ensuring a safe path of travel through the work zone. Per police department protocol, the department scheduler contacted the next available officer on the overtime list and offered the "extra duty" job, which was accepted. The "extra duty" job did not conflict with the officer's regularly scheduled patrol shift from 4:00 pm to 12:00 am. The officer was ultimately responsible for ensuring the general safety of any large vehicles entering and exiting the work zone. The officer arrived at the worksite at approximately 7:30 a.m., in a marked police vehicle, in full duty uniform, and wearing his required high visibility jacket.

The officer conducted traffic control activities throughout the day, and also ensured that pedestrians did not walk into the work zone, where the private construction company had dug a large hole in the road near the edge of the sidewalk.

At 3:35 pm, the construction company began moving their dump truck within the work zone, which partially backed into the traffic lane and made contact with Vehicle 1, which was traveling through the work zone. At this time, the officer was observed to be seated in his police vehicle with its warning lights turned off, overhead running lights turned on, which did not flash or sequence. The dump truck made impact with passenger side of Vehicle 1. The force of the impact with the dump truck caused Vehicle 1 to be pushed into oncoming traffic, causing Vehicle 1 to hit Vehicle 2 in a head-on collision. Both passengers Vehicles 1 and 2 sustained significant damage, requiring both drivers to be extricated and transported to a nearby hospital. Approximately one (1) month later the Town received a formal notice of intent to file a lawsuit alleging that the officer did not act in accordance with the contract and failed to ensure the work zone was safe for passenger vehicles to enter.

Liability Investigation:

Liability appears to be present for both the construction company and the police department.

Construction Company: The Company's investigation identified that the dump truck operator did not follow their driving policy of utilizing a spotter when backing into traffic. In doing so the operator contributed to the cause of the accident. CIRMA is currently seeking subrogation against the company.

Police Department: Although this accident occurred five (5) minutes after the time outlined in the contract between the police department and Construction Company, the officer was onsite at the time of the accident. In the officers witness statement, he notes that he was checking his department cell phone to determine what his evening patrol assignment was going to be. He states he heard the backing signal however, he did not look up or exit his vehicle.

Operator of Vehicle 1: There does not appear to be any contributing liability to the operator of this vehicle. He was well within the work zone when the dump truck made contact with his vehicle at the passenger's side door. The operator was traveling at approximately 25 mph through the work zone and had his headlights on. The operator states that the dump truck was stationary and not moving when he entered the work zone. The dump truck driver began to back up as he was within a very short distance from it. The operator states he did not see the parked police vehicle or an officer until after the accident.

Operator of Vehicle 2: There is not liability assigned to this operator as he was traveling within his lane and was also traveling at a lower rate of speed through the work zone. He does state that he observed the police vehicle on the side of the work zone. He also indicated that the view of Vehicle 1 was obstructed by the dump truck. Vehicle 2 operator states that the police vehicle did not have its emergency lights activated and observed the officer sitting in the vehicle.

Outcome

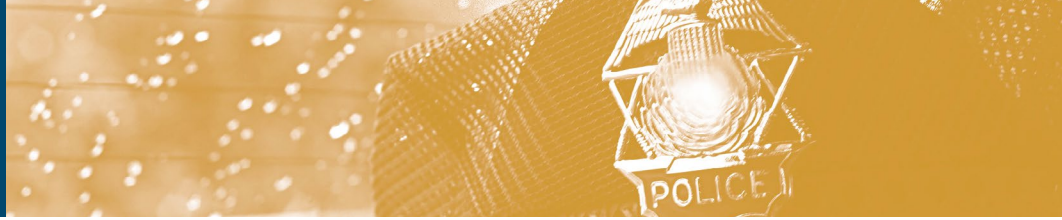
Both passenger vehicles were totaled and needed to be replaced. The combined value of both vehicles was \$62,500.

Vehicle 2 operator sustained minor injuries and was treated and released from the hospital the same day. Total medical bills was approximately \$2,500.

Vehicle 1 operator sustained significant injuries consisting of:

- A large laceration across the forehead, requiring ten (10) stitches to close
- Three fractured ribs
- Plastic surgery to his forehead to reduce scarring

- Continued next page



- Fractured left arm
- A fracture to his right ankle requiring surgical intervention to repair
- Plastic surgery to his forehead to reduce scarring

In addition, a claim was made for loss of consortium, distress, anxiety and depression.

There was a psychological overlay to this claim which contributed to the claim's severity. CIRMA received an initial settlement demand of \$500,000 and the claim ultimately settled for \$250,000.

Total value of the claims was \$315,000:

- Property \$62,500
- Indemnity \$250,000
- Medical Bills \$2,500

CIRMA Recommendations:

Based on the information presented in this scenario, CIRMA Risk Management recommends the following:

- Review of the contract language between the third party construction company and the department providing an officer.
- Consider implementing a best practice to have overhead warning lights activated on police vehicles while stationed in work zones.
- Ensure the positioning of the police vehicle and officer are visible for oncoming traffic in both directions – this may require review of the work zone design to identify the safest location.
- Ongoing training and communication regarding an officers roll in work zones.
- Ongoing training and communication of departmental policies and procedures for while on scene at a work zone and release procedures.
- Instructing officers to leave at their scheduled time.

Questions? Ask your Supervisor or CIRMA Risk Management Consultant.

Dealing With Presumptions of Death

Background

On the date of loss, the claimant (decedent) sent an alarming text to family members instructing them to call the police and have them respond to his home. Officers were dispatched to the location and the Chief of Police also responded. Upon arrival at the scene, police personnel found the claimant hanging in his shed along with a suicide note. The Chief of Police declared the scene to be a crime scene and had officers begin putting out caution tape. The police personnel on scene checked the claimant's pulse and found none. Subsequently, the Chief of Police made a determination that the claimant was dead. Several moments later, Emergency Medical Services (EMS) was requested, dispatched and arrived on scene to make a presumption of death. Upon arrival, EMS had found a heart rhythm and worked to cut and extract the decedent from the hanging position. Ultimately the claimant was transported to the hospital with CPR in progress. The claimant was pronounced deceased in the hospital.

The Notice of Intent to File Suit alleges negligence against the police departments, its officers, Chief of Police and Town for:

- Prohibiting emergency medical personnel from entering a shed where the claimant (decedent) was found adjacent to his home. The notice alleges that police personnel on scene prohibited the EMS staff from entering the shed and tending to the victim who was in need of medical treatment.
- The police personnel on scene failed to assess and/or evaluate the claimant's (decedent) condition to determine if medical assistance was needed, for determining the shed to be a crime scene, and not allowing the EMS staff into the scene before making such medical assessment.

Facts:

According to the Chief of Police, the claimant was having difficulty coping with the death of his wife, who passed away a month earlier. Subsequently, claimant had been placed on suicide watch and was living with family members.

Apparently, on the first day, the claimant went back to his house after his wife's death, he began calculating his own death. The police department had received numerous calls from family/friends expressing concern for the claimant after receiving text messages from him just minutes before his suicide. The text messages requested that they send the police to his address.

After receiving these calls, the police department responded to the residence. It is noted that they were aware that the decedent's wife had just passed away one month prior and the family expressed concern for his well-being. Two police officers were the first to arrive on the scene and found the claimant with a noose around his neck as well as evidence of extreme lengths to ensure that the knot did not come undone. The officers did not check for a pulse. After a few minutes the Police Chief and EMS Captain arrived. The Chief looked inside the shed and declared it a crime scene – as it needed to be confirmed homicide vs. suicide – and had the area roped off. The physical posture of the claimant's body – a much distended, severely broken neck – assisted in the Chief of Police's determination that the claimant was deceased.

The paramedics were called to the scene by the police officers. An EMT/firefighter from another member town arrived on the scene and requested entry to the shed. The Police Chief denied entry stating that the claimant was deceased and they were awaiting the paramedics to arrive to make the presumption of death. EMT's cannot make presumption of deaths.

Approximately 2 minutes later a paramedic arrived on scene. The paramedic was allowed to enter the scene and begin his process for a presumption of death. The paramedic placed the cardiac monitor onto the claimant; who has not yet been cut down from the noose. At this time, the EKG machine was showing that the claimant had some sort of electrical heart activity. The paramedic indicated that he could not make a presumption of death, that the claimant needed to be cut down and Advanced Life Support (ALS) activities were initiated. The Paramedic and EMT's then transported the claimant to the local hospital where he was pronounced dead.

The police department called in the Connecticut State Police Major Crime Squad to "process" the scene. This was initiated by the Chief of Police because there were now 2 deaths, both 30 year olds in less than 2 months. The State police found that one death was caused by a medical condition, while the second was classified as a suicide; which was confirmed by the Office of the Chief Medical Examiner's Office.

The EMS Captain wrote a report to the Fire Chief and one of his commissioner's, criticizing the police and indicating that they had prevented him from initiating resuscitative efforts in a timely fashion which could and would have resulted in emergency personnel's ability to revive the claimant. The EMS Captain accused the Chief of relegating him to traffic duty under circumstances where he should have been at the patient's side attempting resuscitative efforts. These actions would include advising him:

- Not to pull the ambulance into the driveway, and

- Continued next page



- That this was a crime scene, that they would need a paramedic to pronounce, and that the fire department would be useful with regard to gaining entry to the residence.

Timeline:

The timeline of events shows that approximately 15 minutes had elapsed between the claimant's text messages to family members and the arrival of the first police officers on scene, and another 15 minutes from the time the first EMS personnel arrived on scene and when they were allowed to enter the shed.

- 11:06 am - Claimant sent text messages to dad and friends
- 11:14 am - Police receive calls from claimant's family and friends; officers are dispatched to the scene
- 11:21 am - First 2 police officers arrived on scene
- 11:30 am - First 2 officers find the claimant's body hanging in shed
- The two initially dispatched officers proceeded to the claimant's home where they were shortly joined by the Chief and Captain. The claimant's house was locked and the officers were making observations around exterior of the home. Eventually, one of the officers observed the claimant hanging in the shed. The officer initially thought what she saw in the shed was a dummy, she did not think it was real. Ultimately, upon further investigation with the Sergeant, it was determined to be an actual person – the claimant.
- 11:32 am - Chief of Police and EMS Captain arrive on scene. The EMS Captain is assigned to "traffic duty" by the Chief of Police
- 11:35 am - Fire/EMS arrive on scene, and are denied access to the claimant's body
- 11:46 am - Chief of Police allows EMS to enter shed
- 11:47 am - Paramedic arrives on scene and enters the shed to begin presumption of death process. Claimant is found to have some type of cardiac electrical rhythm and ALS is started.

Liability Assessment:

There are 3 key issues that were identified:

1. It appears that the Police Chief did not have knowledge of the existing State guidelines with regard to resuscitation and determination of death – *Resuscitation Initiation and Termination 6.15*;
2. It appears that there is a potential failure to properly train the officers in the EMS protocol once he became aware of it, based on the clear absence of knowledge on the part of all responding officers concerning the EMS protocol at the time of the response to the claimants home;
3. There was an attempt to maintain that the Chief's report contains false statements which the Chief knew or should have known were false.

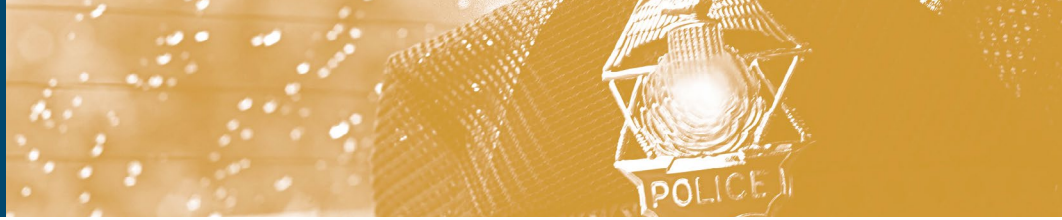
The Chief knew that he needed to call a paramedic to make a presumption of death and was waiting for the paramedic to pronounce death, yet had already concluded that the claimant was dead. This created a conflict and disconnect that the plaintiff's counsel argued, stating that the whole reason to have the paramedic pronounce death **is to discontinue resuscitative efforts**. The response from the Chief of Police was that "...it is a process and that we need to follow the process which requires a finding of death...". This does not mean that officers, when faced with circumstances of obvious death, do not in the field reach that conclusion prior to a presumption of death. **This is inconsistent with the four corners of the guideline.**

The Chief of Police completed a 12 hour refresher course and 4 course hours on resuscitation in December of 2015, some 3 months prior to the incident in question.

Concerns existed about the EMS protocols and their apparent conflict with the Chief's orders. The Chief recognized the concerns and focused on his overall assessment that the decedent was obviously dead based on appearance and that he was treating the matter as a crime scene.

In his report, the Chief of Police acknowledged that:

- CPR was not started until approximately 12:07 pm.
 - The ambulance arrived at 11:35 am, which is the quickest ALS could have started. However, the EMS Captain is accusing the Chief of relegating him to traffic duty under circumstances where he should have been at the patient's side attempting resuscitative efforts. The Chief of Police said the EMS Captain wanted access to the shed – which



he initially declined - as it was a crime scene and an EMT could not do a presumption of death, this could only be done by a paramedic. After a few minutes passed, the Chief of Police; who was dealing with arriving family members and trying to keep them away from the shed; told the EMT he could take a look if he wanted to since the medic had not yet arrived. The EMT went into the shed, looked at the body and took no action.

- The officer who initially discovered the claimant's body was a former EMT with previous EMS field experience and training- YET she did not take the claimant's pulse. In fact, no one took a pulse. She did not enter into the shed nor go up to the body, but rather stayed near the shed's entrance. The officer worked for both Danbury Ambulance and Vin Tech EMS, which is an EMS service provider that provides staffing needs to various ambulance providers. The officer indicated that she has responded to several attempted hangings in her previous EMS positions, and from what she recalls, all resuscitation efforts were failed attempts. Once police recognized the claimant's body they were quick to dispatch the fire department which brought EMS to the scene.
- Responding officers were certified in CPR, AED, and EMR by the State of Connecticut.
 - The police are supplemental first responders. All police officers are certified through American Red Cross in first aid, CPR and AED, and are certified EMR's. This would have allowed BLS resuscitation efforts to begin at 11:21 am - only 15 minutes after the initial call from the claimant's family.
- All police cars were equipped with AED's however, no one thought to use it.
 - Per the officers on scene, there was no question the claimant was deceased when they arrived on scene. The decision was made by the officers responding not to cut the claimant down. The Chief confirmed there are no written departmental policies that state when investigating a hanging the body must immediately be cut down. They have general investigation policies, not specific policies that refer to suicide by hanging.

An EMT has an obligation to render medical care in the field until one is confident the victim is dead and that the State of Connecticut EMS guidelines/protocols are adhered to. Irrespective of whether EMS can or cannot make a presumption of death, he has a statutory obligation to render medical care in the field. EMT protocols require resuscitation efforts for non-breathing and pulseless patients until such time that death can be pronounced.

State of Connecticut EMS protocol *Resuscitation Initiation and Termination 6.15* states-

"Resuscitation must be started on all patients who are found apneic and pulseless UNLESS the following traumatic injury or body conditions exist: decapitation, decomposition or putrefaction, transection of the torso or incineration."

- The police vehicles were all equipped with AEDs but no AED was applied to the claimant.

The Police Chief declared this a crime scene immediately after locating the body. He did not allow the EMS/Fire Captain to enter the shed right away. There was a delay, after some discussion and thinking perhaps he could do a presumption of death, he allowed him to enter. He entered with no equipment. The EMT came out of the shed as the paramedic arrived at the shed and entered with EKG equipment. This is when, after hooking the victim to the EKG machine, pulseless electrical activity (PEA) was detected. The claimant was then cut down and transported to the hospital with resuscitation efforts.

Settlement Amount:

Based on multiple factors; expert witness, testimony from the Chief of Police, the Towns executive leadership; it was determined that the best course of action would be to enter into settlement negotiations. **This claim was ultimately settled for - \$1,050,000.**

CIRMA Recommendations:

CIRMA Risk Management is seeking feedback from the Law Enforcement Advisory Committee on the recommended best practices to reduce liability associated with this type of claim:

- Ensure that a policy exists which clearly explains an officers responsibilities, based on medical certification levels, when responding to medical calls, including trauma's.
- Ensure that all officers are versed and trained to the proper EMS protocols; specifically pertaining to their:
 - Obligations to render care as certified EMS professionals,
 - Obligations to initiate care based on their level of certifications,
 - Obligations to continue care until directed otherwise by the highest level of certification on scene or a doctor issuing medical control.



- Ensure that proper documentation is maintained in each officers' file as to their medical certification and training on EMS protocols and department policies.

In addition, a claim was made for loss of consortium, distress, anxiety and depression.

Questions? Ask your Supervisor or CIRMA Risk Management Consultant.

De-escalation and Training Breakdowns

Background

A police officer on patrol observes a motorist not wearing his seat belt and initiates a traffic stop. Immediately and throughout the traffic stop, the driver of the vehicle is belligerent and agitated with the officer. Despite multiple attempts by the officer to obtain the required information to issue the seat belt violation, the driver refuses and continues to escalate his language and attitude and requests a supervisor. After approximately 20 minutes, the officer requests backup. During this time, several patrol vehicles passed them on the side of the road but did not stop.

Once backup arrives, the two officers attempt to remove the driver from the vehicle, at which time the driver and one officer get into a physical confrontation. The second officer, who is one month off of FTO training, engages in the altercation. Ultimately, this rookie officer determines that additional control measures should be taken and announces she is going to use her TASER; however, as she gives the verbal warning about the use of the TASER, she draws her firearm and discharges one (1) round into the back of the driver. The driver ultimately collapses on the ground. The driver is transported to the hospital with a gunshot wound to the middle of his upper back. He is initially treated in the emergency room and then was brought into surgery to have the bullet removed. He is hospitalized for several days and suffers from numbness of his left arm and hand.

The rookie officer resigned from the police department after this incident.

Facts:

- At approximately 12:30 pm a police officer on patrol, while sitting at a traffic light, observes a black SUV in the oncoming lane at the light. The officer has a clear line of sight through the vehicle windshield and notices that the driver was not wearing his seatbelt.
- Upon the light turning green, the SUV proceeds through the intersection and continues down the road. The officer activates his warning lights and sirens and attempts to catch up to the black SUV. The officer stated that he never lost site of the vehicle.
- The officer pulls behind the SUV and initiates a traffic stop. Hearing the siren and seeing the activated emergency lights, the driver of the SUV pulls his vehicle to the right side of the road and stops.
- The officer notifies dispatch of his location and then exits his police cruiser.
- Upon arriving at the driver side window of the SUV, the officer identifies himself and provides an explanation to the driver for the reason of the traffic stop. Immediately, the driver becomes verbally agitated and yells at the officer several times that he is a racist and asks "Don't you have anything better to do than bother me for a seatbelt violation?"
- The officer makes multiple attempts to obtain the driver's information – driver's license and proof of insurance – and explains that this is a minor violation and all the driver has to do is comply and he will be on his way in less than five minutes.
- Despite the officer's attempts, the driver continues to yell and become belligerent with the officer.
- After approximately ten minutes, the driver of the SUV asks the officer to call his supervisor; he specifically said, "I want to talk to your supervisor."
- The officer denies the request stating that "He is not holding court on the side of the road." The driver again requests a supervisor.
- The officer again denies the request, telling the driver he is "being ridiculous" and that he would have been on his way if he just complied. The officer then states that the driver will go to jail over a seat belt violation if he does not provide the information requested by the officer.
- The driver denies the request again and then requests to speak to a supervisor as it is his right. The officer denies this request stating "It is not your right, and he is not going to call a supervisor to listen to him tell the driver the same thing."
- The driver of the SUV begins to yell at the officer, at which time the officer requests backup to his location.
 - It is noted that several patrol vehicles have passed the scene prior to this request and did not stop or communicate with the officer to determine if he needed any assistance.
- A second officer, who is one month off FTO training arrives on scene. She is notified by the first officer that the driver is going to jail and that they will need to extract him out of the vehicle.

- Continued next page

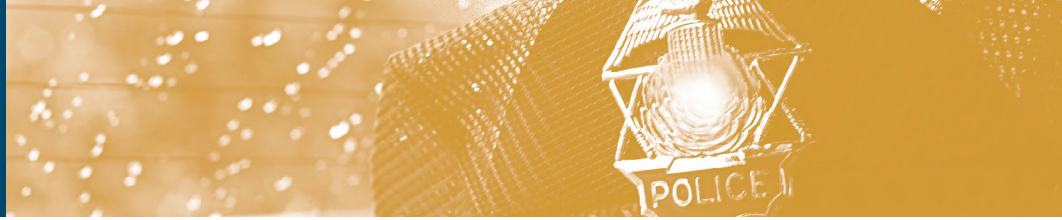
- The female officer proceeds to the passenger side of the SUV, opens the door, enters the SUV, and begins to engage the driver to try and push him out of the vehicle, while the male officer is pulling the driver through the open driver-side door.
- Upon exiting the vehicle, the driver engages in a physical altercation with the male officer, punching him in the head and ribs. The male officer and the driver fall to the ground and continue to fight.
- Seeing this, the female officer exits the SUV and attempts to engage in the altercation. She begins notifying the driver to “put your hands behind your back or I will tase you.” She provides several commands to the like, with no compliance by the driver. After multiple unsuccessful attempts to take the driver into custody, the female officer yells out “Taser, taser, taser”. however, she grabs her department issued firearm, removes it from the holster and fires one round into the back of the driver. As a result, the driver collapses to the ground, and can be heard screaming in pain on the dash cam video.
- The female officer can also be heard saying “Oh my God, I thought I grabbed my TASER, oh my God”.
 - The female officer ultimately resigns from the police department as a result of this incident.
- Emergency Medical Services (EMS) arrive on scene and transport the driver to a local hospital where he is treated in the emergency room, stabilized, and transferred to surgery to have the bullet removed. The driver was admitted to the hospital where he remained for several days.

Investigation:

- It was determined that the female officer was carrying her TASER on her “strong side” next to her firearm.
- The department had completed de-escalation training.
- The department had a Standard Operating Procedure indicating that when a civilian requests a supervisor, the officer should inform the civilian that the request will be made and based on the supervisor’s availability, the interaction with the officer would be extended. The officer then “shall” notify dispatch of the request.
- The male officer becomes frustrated during the interaction with the driver and makes a decision to arrest the driver for interfering with a police officer, rather than calling for a supervisor or to release the individual and follow up with other avenues to provide the citation to the driver.
- The driver of the vehicle was not wearing his seat belt.
- The driver of the vehicle was not compliant.
- The female officer entered the vehicle on her own accord. She mentioned in her statement that she interpreted the direction of the male officer to be for her to get in the vehicle.
- The female officer stated that she was not aware of the protocol to wear the TASER on her support side in the ‘cross draw’ fashion and that her FTOs never mentioned it to her during the time period she was on duty with them.
- The department was able to produce training records for all officers involved in this scenario that illustrated they had gone through de-escalation training and less than lethal weapons training – specifically on the utilization of the TASER.
- During the deposition of the training officer, it was determined that, although the department did not have a formal policy on the placement of the TASER on the duty belt, the training officer stated that it is “common sense” not to carry the TASER next to the gun and assumed that the FTOs explained that to the female officer.

Damages:

- The driver sustained a gunshot wound to the upper back, between the shoulder blades. The bullet damaged several nerves causing permanent numbness and loss of fine motor skills in the driver’s left arm and hand.
- As a result of the incident, the driver suffered from nightmares, mood changes, and depression and was subsequently diagnosed by a psychologist with Post Traumatic Stress Disorder.
- The driver was hospitalized for several days as a result and continues to treat with both physical and occupational therapists as well as with a psychologist.
- It was determined that, although the driver did not comply with the officers commands, both the male and female officers failed to comply with department policy. It was further determined that the lack of policy for the carrying of the TASER on the duty belt contributed to the OIS.
- The claim was ultimately settled for \$325,000; which included medical bills, attorney fees and indemnification.



Recommendations:

- Retrain all officers on the department regulations and policies on civilian requests to speak with a supervisor.
- Develop and train all officers on a policy to carry the TASER on the support side in the cross draw position.
- Train officers on the dangers of entering vehicles of potential suspects.
- Retrain FTOs on the department policy for carrying a TASER on the duty belt, and require FTOs to document their corrective actions for rookie officers when they are not in compliance with department policy.
- Continue to provide de-escalation training to officers, including simulated scenarios to illustrate how best to avoid escalating to a physical use of force.

causing permanent numbness and loss of fine motor skills in the driver's left arm and hand.

- As a result of the incident, the driver suffered from nightmares, mood changes, and depression and was subsequently diagnosed by a psychologist with Post Traumatic Stress Disorder.

Questions? Ask your Supervisor or CIRMA Risk Management Consultant.

Frequency Breeds Severity

Background

A municipal police department experienced reported ten Workers' Compensation claims that were reported by their officers within several weeks of each other. Each claim was a result of an officer striking the back of their heads at the start of their assigned shifts. Each officer immediately reported the injury/incident to the Sergeant. Subsequent First Reports of Injuries were submitted through CIRMA's NetClaim.net Online Portal.

The severity of the injuries sustained by the officers ranged from bruises to concussions; several of the officers required sutures. In addition, three officers were placed on total disability for a combined period of forty-one days by their attending physicians. Consequently, there were associated indirect costs due to the police department needing to backfill the injured officers' positions and paying overtime.

Investigation and Damages/Injury

Through the claims investigation, CIRMA determined:

- That the Supervisor's Accident Review Form:
 - Listed "Nature of doing the job" as the contributing factor to the incident/injury.
 - Did not have an entry in the Identify Recommendations for Corrective Action section.
- The officers were striking their heads on the trunk latch of the police cruiser when placing their gear bags in the trunk of the vehicle.
- The trunk in each vehicle was filled with the following:
 - Required vehicle electronic equipment
 - Road flares
 - Spare tire
 - First-aid equipment
 - Department-issued rifle and rifle accessories

Due to the magnitude of equipment located in the trunk, there was minimal space for the officers to place their gear bags. As a result:

- The officers needed to partially lean into the trunk to place the gear bag in the open spot and position the bag to not disturb or damage any of the equipment installed in the trunk.
- Following placement of the gear bag in the trunk, the officers would proceed to lift their head in an upward position and step backwards. This specific movement was found to be a major contributing factor for causing the injuries.
- The officers were unaware of any other gear bag placement options.
- The reported claims were incident-only, medical-only and lost-time claims. The lost-time claims had a restricted duty component.
- Since the Chief of Police would not accommodate restricted duty, the officers remained on temporary total disability status until returning to full-time police duties.
 - Per the police department's collective bargaining agreement – an injured officer would receive 100% of their salary for one year. This contributed to the increased total cost of risk for these claims.

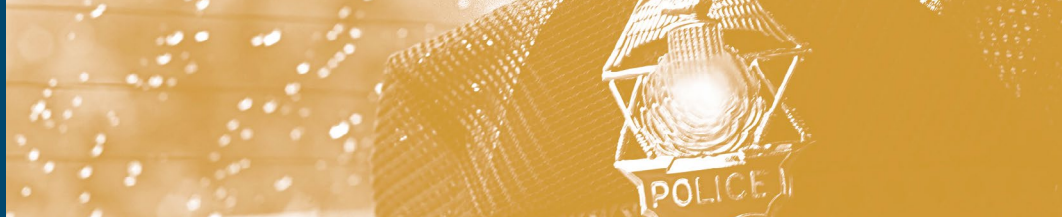
Outcome

The claims were deemed compensable since the officers were acting within the scope of their assigned duties at the time of their injuries. The severity breakdown for each claim is listed below:

- Incident only claims Frequency = 5 Severity = \$0
- Medical only claims Frequency = 2 Severity = \$1,000
- Lost work time claims Frequency = 3 Severity = \$50,463

Total Direct Incurred Exposure = \$51,463

- Continued next page



Recommendations:

- **Conduct regular Root Cause Analysis (RCA) Training for Supervisory Officers** - The purpose of reviewing both incidents and accidents that cause injury or damage is to identify the root cause of the incident in order to prevent the recurrence of future accidents. The focus should be on the activity at the time of the incident, not the injury. Unfortunately, too often the review process is limited to completing the necessary insurance paperwork. RCA is a systematic process for identifying the “root cause” of problems or events and an approach for responding to them. RCA is based on the basic idea that effective risk management requires more than merely “putting out fires” for the problems that develop, but finding a way to prevent them. Root Cause reviews are critical in identifying, controlling, and eliminating workplace health and safety risks.
- **Implement a formalized Return-to-Work (RTW) Policy** - An effective workplace RTW Program is the best way to manage costs and improve the chance of recovery. Studies have shown that injured employees recover faster when they return to work, and that the longer an employee is out of work, the less likely they are ever to return. Additionally, the length of time an injured employee is absent from the workplace directly impacts the overall Total Cost of Risk.
- **Reduce the salary continuation benefit** - These supplemental wages are provided in addition to the non-taxable statutory Workers’ Compensation benefits that injured employees receive. It is an unintended consequence of the federal and state tax codes that exacerbates the cost burden of these benefits on municipalities. Because Workers’ Compensation benefits are non-taxable, salary continuation payments are taxed at a lower rate than full, regular wages, often making it more lucrative for an injured employee to stay at home, collecting benefits, than it is to return to work. It is not uncommon for employees to receive five to ten percent more money, after taxes, in workers’ compensation and salary continuation benefits than they would receive working. In short, salary continuation benefits may “incentivize” employees to prolong recuperation, extend treatment, and delay return-to-work.

Questions? Ask your Supervisor or CIRMA Risk Management Consultant.

Search of In-Custody Suspects

Background

The incident occurred on a Sunday evening after a man was arrested on suspicion of impaired driving. Once placed under arrest, the suspect was placed in the back of a patrol vehicle. Upon completing his investigation at the scene, the officer then entered the car and began transporting the suspect to the station for processing. During the transport, the suspect was not seat belted and was able to manipulate the position of his hands to the front of his waistband and pulled out a nine-mm, semi-automatic handgun.

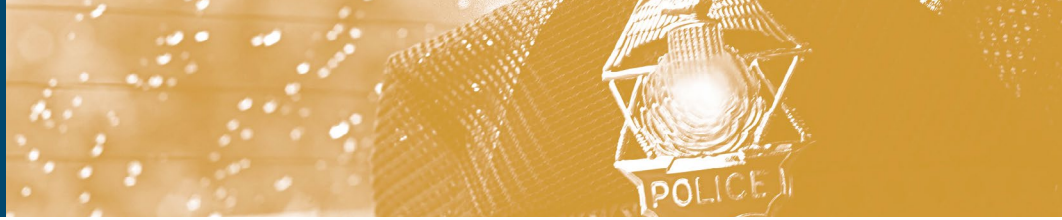
Investigation and Damages/Injury

A thorough investigation was conducted:

- Patrol officers observed a late model Honda civic operating erratically and initiated a traffic stop.
- During the officer's investigation as to the cause of the erratic driving, the officer determined that the suspect was potentially under the influence of alcohol or drugs. The officer requested a backup officer and a supervisor to his location.
- During this time, the male suspect was compliant and listened to and obeyed all of the officer's lawful commands.
- Upon arrival of the backup officer, the initiating officer explained that he suspects that the male suspect was under the influence of alcohol or a controlled substance and was going to conduct a field sobriety test. After failing the tests, the suspect was placed into custody with his hands handcuffed behind his back (as is standard protocol and proper handcuffing procedures). The male suspect did not resist and continued to comply with the officer's commands and directions.
- As the supervisor arrived, the initial officer asked the backup officer to place the suspect into his patrol vehicle so that he can brief the supervisor on what was occurring.
- The backup officer placed the suspect in the patrol vehicle, did not seat belt him, and closed the door.
- After briefing the supervisor and securing the suspect, both officers searched the suspect's vehicle incident to arrest. The vehicle was towed. After completing the search, the arresting officer transported the suspect to the station for processing.
- During the transport, the officer observed the suspect "squirming" around in the back seat, however, did not pay too much attention to it as he assumed it was because the handcuffs were uncomfortable.
- Approximately halfway to the station, the officer heard a "thud" in the rear of the vehicle. Again he did not pay attention to this as he thought that it was the suspect accidentally kicking the back of the seat as he moved around.
- Upon arrival at the station the officer opened the back door and noticed that there was a 9mm handgun in the area around the suspect's feet.
- The officer drew his weapon and gave the order for the suspect not to move and called for assistance, they removed the suspect from the vehicle and secured the firearm, without incident.



- Continued next page



- The suspect stated that the gun was not his. However review the of the in car CCTV system clearly showed that the suspect removed the gun from his front waist band and dropped it to the floor of the patrol vehicle (See below screen shot):

Investigation and Damages/Injury - continued

- The backup officer stated that when he searched the suspect, there was not any indication that the suspect was carrying a concealed weapon. During his interview, the suspect stated that the officer only lightly searched his person and did not search his waistband. The officer asked the suspect if he had any weapons, to which he replied “no”, and was then placed in the back of the patrol vehicle.

Outcome

While there were no injuries associated with this incident, the outcome could have been fatal for both the officer and suspect.

Recommendations:

- Conduct regular training and communication to sworn officers on the importance of completing a thorough and complete search of any suspect placed into custody.
- Seat belt all suspects placed in the patrol vehicle.
- Consider conducting a secondary search of suspects when they demonstrate erratic behavior while secured in the back of the police vehicle.
- Train officers on situational awareness and understanding erratic behaviors.

Questions? Ask your Supervisor or CIRMA Risk Management Consultant.

Communicating Vendors' First Amendment Rights at Town-Sponsored Events

Background

Municipalities dedicate countless hours and dollars every year planning and hosting family-friendly activities for their communities. Among the many pre-event considerations CIRMA members face, running a fair and efficient vendor application process is among the most important. Recent events have identified a need to reexamine how towns develop and implement the vendor application process in order to mitigate liability.

Scenario

A municipality was hosting its annual Town Fair, which has taken place during Labor Day Weekend every year for nearly 100 years. The event consists of a number of family-friendly activities, including carnival rides and games, agricultural and craft exhibits, food vendors, merchandise vendors, and more. The town has conditions and considerations that the vendors must follow in order to be allowed to display their products; these conditions and considerations are posted on the fair's website and are communicated during the vendor application process.

On the first day of the three-day event, the president of the Fair Commission, who is an agent of the town, was notified by a patron of "an inappropriate exhibit" located in the merchandise vendor section. The patron alleged that the products being sold were offensive and not consistent with the family-friendly culture of the fair. Immediately, the president of the Fair Commission went to the booth in question to better understand the situation.

At the booth, the president identified products, such as shirts and towels, being sold with images of marijuana leaves and other smoking paraphernalia. The president agreed with the patron, indicating that the images were inappropriate and the products should not be sold at the event; however, the vendor, an alternative pain treatment manufacturer, argued that the products being sold displayed legal substances and that it is within their first amendment right of freedom of speech to display these images. The president countered and said that the products were not approved by the Fair Commission and that they must be removed, or that the vendor would be removed from the event. Ultimately, the vendor was removed from the event due to their refusal to stop selling the products.

A few months later, the vendor filed a notice of intent to sue against the town and its officers, alleging violation of their first amendment right of freedom of speech. The town defended its decision, stating that it is within their right to control what images can be displayed and that the vendor violated the fair's policy of getting the merchandise pre-approved during the application process. Ultimately, the judge ruled in favor of the vendor. The Town was responsible for paying \$85,000 to the vendor, which included payment for the vendor's attorney fees and lost wages as a result of being asked to leave the three-day event. But how can this be?

Investigation - Municipalities' Rights

The Federal Supreme Court has established and continues to enforce that governmental entities are protected by the Government Speech Doctrine. The Government Speech Doctrine recognizes that a government entity "is entitled to say what it wishes" and to select the views that it wants to express. In essence, the government is not barred by the Free Speech Clause of the First Amendment from determining the content of what it says and can engage in viewpoint discrimination.

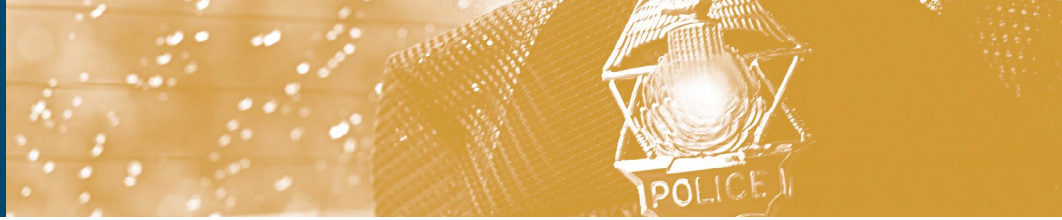
With the Government Speech Doctrine in mind, the town has created policy consisting of conditions and considerations that vendors must follow during the event. Language contained in this policy stated, "All vendors must have professional looking concessions," and, "Pictures of your set-up and lists of products you wish to sell should be included with your application." The town contended that, by asking the vendor to remove the products deemed to violate the fair's policy, they were acting within their rights.

The judge ruled that the fair acted within its right to exercise its discretion in determining which vendors comply with the event's family friendly culture; however, the fair inconsistently applied its own policies, as they do not always require vendors to submit photographs of the merchandise being sold, and was unreasonable in its treatment of the vendor.

Recommendations

The Case Example confirms a municipality's rights to control free speech at its events; however, it also highlights the need to consistently enforce policy. Below are some useful tips that CIRMA members can follow to better protect themselves from Violation of Rights claims.

- Continued next page



Policy: Develop and adopt a policy consistent with the municipality's right under the Government Speech Doctrine. Consider submitting the policy to CIRMA Risk Management for review and recommendations. In addition to CIRMA's review, the municipality's legal counsel should review language to ensure it is consistent with applicable state and federal laws.

- Within the policy, consider omitting language that states the municipality/commission/or event organizer will review all products and materials.
- Consider including language such as, *"The [event organizer] reserves the right to refuse any exhibit, item, action, activity it considers to be inappropriate to its reputation or image, and this includes the right to ask the exhibitor to remove any exhibit or item or cease such actions or activities."*

Communication: Communicate the policy to all vendors and merchants prior to the event, typically during the application process or thereabouts.

Response: Educate appropriate event staff and volunteers of this policy. It is recommended that the decision to remove items or cease activities is controlled to one person or a few people to ensure that the policy is enforced equally and fairly. However, event staff and volunteers should be informed on who to notify when inappropriate exhibits, items, actions, or activities are suspected or observed.

Questions? Ask your Supervisor or CIRMA Risk Management Consultant.

Law Enforcement Liability - Use-of-Force

BACKGROUND

Law Enforcement Liability claims citing Officer's Use-of-Force continue to negatively impact severity. While overall Law Enforcement Liability claim severity had been declining between PY 2015-16 and PY 2017-18, the percentage of claims severity referencing Officer's Use-of-Force relative to total severity has been steadily increasing. In PY 2018-19, Use-of-Force claims exceeded the \$3.0M threshold for the first time since PY 2013-14. Use-of-Force claims make up approximately 53% of all Law Enforcement Liability claim severity.

Since July 1, 2015, the CIRMA Liability-Auto-Property (LAP) Pool has experienced \$6.2M in Use-of-Force claims, led primarily by \$4.1M as a result of Officer-Involved Shootings. The remaining severity is associated with a variety of uses of force including TASER utilization. Included in this severity are payment to the claimant as a result of bodily injury (\$5.4M) and Legal Expenses (\$0.6M).

The large loss incident described below recently settled for over \$2 million and was a result of the deployment of less than lethal use-of-force TASER deployment.

INVESTIGATION

The claims investigation revealed the following facts:

- The decedent had an extensive criminal history, including charges for violent crimes such as assault.
- The decedent had a lengthy history of drug and alcohol abuse and mental health illness; he was diagnosed with a bi-polar disorder and depression.
- The decedent had a son and 4 siblings. He lived with his grandmother, who raised him.
- On the date of the incident, local law enforcement has been called to a parking area for a potential assault-in-progress. Upon arrival, the officers found the decedent standing near a vehicle with a smashed windshield and side window. The officer's investigation found that the decedent had thrown rocks at a vehicle as it passed by him, smashing the windshield and passenger side window. At this time the decedent offered no explanation to his actions, and was cooperative, he did appear to be intoxicated. He was ultimately taken into custody without incident and charged with damaging the passing vehicle. He was transported to the local police department for processing. At that time, it was determined that the decedents blood alcohol level was .241.
- The decedent was then placed into a holding cell where he became agitated and began removing his clothes. Officers responded and opened the cell door. The decedent immediately charged out of the cell and became combative with the officers. As a result, the officers responded by punching the decedent in the head and subsequently deployed a TASER for 20 seconds. The TASER had little effect – it was determined that one of the TASER lines was broken sometime during the altercation. After multiple attempts to physically control the decedent he was subdued and placed into handcuffs. The decedent was left laying on the cell floor. Approximately 5 minutes later, after seeing movement from the decedent, officers entered the cell again to check his condition, and found him in medical distress. The officers called for medical assistance, which took 7 minutes to arrive. During this time, officers did not attempt any lifesaving or life-preserving efforts. EMS arrived and initiated advanced life support efforts and transported the decedent to a local hospital where he later died.

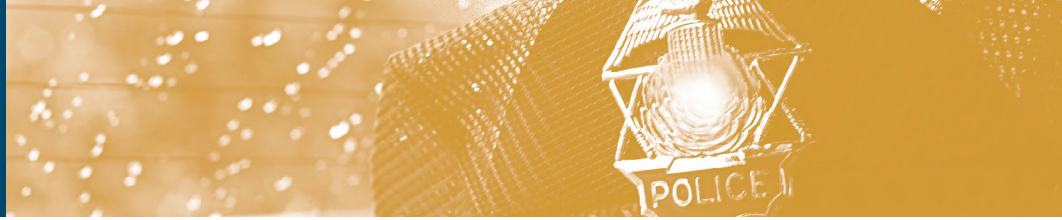
CLAIM LIABILITY ASSESSMENT

The claims were accepted at 100% since the officers were acting within the scope of their assigned duties of the incident. The 12 minute video tape showed that there was little effort to preserve life. It was further determined that one of the officers on scene had been trained in the use of AED's and CPR and offered no assistance. As a result, this claims recently settled for \$2.5 million.

KEY RECOMMENDATIONS/ACTION ITEMS

On July 31, 2020, Governor Ned Lamont signed House Bill 6004 creating Public Act 20-1. The act contains 45 sections with approximately 27 varying sections that address police officer training, oversight, actions in the field, equipment and liability. Public Act 20-1 creates the office of an inspector general to investigate complaints of police misconduct. The act requires police and correctional officers to intervene when witnessing brutality, mandates body and dash cameras, bans chokeholds in most circumstances and clarifies that deadly force can be used only when police exhaust all reasonable alternatives. It also revamps and empowers the Police Officers Standards and Training (POST) Council, giving it the authority to decertify a police officer – revoking a necessary credential

- Continued next page



for employment as a municipal police officer in Connecticut. POST is also tasked with providing training for every police agency in Connecticut, including the State Police, and to help set policies on crowd control and the use of force.

As a result of the findings in this loss and the new legislation identified above it, is recommended that the law enforcement agencies work within the requirement of the new law to investigate these incidents, and provide training relevant to dealing with intoxicated individuals, individuals with special needs, recognizing mental health issues in adults and children (Youth Mental Health First Aid).

Furthermore, it is recommended that law enforcement agencies implement protocols in accordance with the new state legislation in regards to investigating use-of-force complaints, even when not related to the deadly use-of-force by officers.

All Connecticut Interlocal Risk Management Agency (CIRMA) inspections and recommendations are purely advisory and intended to assist our members in risk control and safety procedures. The implementation of recommendations made by CIRMA is the sole responsibility of the member. Observations and recommendations of CIRMA are based on practices and conditions observed and information made available to us at the time of our visit, and do not imply or guarantee full compliance with Local, State or Federal regulations that may be applicable to such practices and conditions. These inspections, reports and recommendations do not signify or imply that other hazards do not exist.

Questions on this topic? Ask your Supervisor or CIRMA Risk Management Consultant.

Training Risks

OBJECTIVES

The objectives of this large loss claim review are to:

- Examine a recent Workers' Compensation claim related to law enforcement training;
- Understand the physical straining associated with certain law enforcement trainings;
- Develop specific risk management best practices to either prevent or mitigate future losses for Connecticut law enforcement agencies based on lessons learned.

BACKGROUND AND INVESTIGATION

- The injured employee was a 36-year old female police officer hired in 2004.
- The officer was assigned and required to attend annual recertification training on the use of her TASER, ASP, and OC Spray.
- On the date of loss, the officer reported for training at 8am and was instructed that the training session would be for handcuffing and arrest and control techniques.
- The training was broken into two (2) segments;
 1. First was a PowerPoint and video review segment lead by an instructor,
 2. The second would consist of hands-on scenarios between partnered officers.
- The injured officer and class completed the first segment of the training and broke for lunch. The class was instructed to return to the training location in one (1) hour for the second segment of the recertification training, which would include takedowns and handcuffing techniques.
- The officer returned to the training facility as required and was partnered with another officer of similar size.
- The second segment of this training focused on using techniques from the "L.O.C.K.U.P." system. Each technique was demonstrated by the class instructor who was a certified instructor in "L.O.C.K.U.P." training.
 - ▶ L.O.C.K.U.P. (Law Officers Combat Kinetics Unarmed Protection) program teaches arrest and control maneuvers for all levels of physical resistance and aggression, with a primary focus on techniques for UNARMED police engagements.
 - ▶ L.O.C.K.U.P. is currently the only standard police arrest and control (Defensive Tactics) system accepted in the state of Connecticut.
 - ▶ L.O.C.K.U.P. empty hand maneuvers can be deployed by trained personnel during violent physical altercations.
 - ▶ It adapts specific arrest and control maneuvers to fit an officer's physical and physiological change during these altercations to control a suspect's movements.
- The instructor ran the physical aspect of the training from 1-2 pm. During this time period, each officer was required to practice takedowns and lockup positions multiple times on their partner. This included:
 - ▶ Having to take each other down to the ground while holding an arm behind their back into the lockup position and kneeling on the same shoulder.
 - ▶ This occurred multiple times, some requiring the injured officer to "tap out."
- In her initial statement, the injured officer mentioned that she did not feel any pulling or popping during the training session. She stated that she only felt sore while in the class.
- The instructor provided a short break to the participants and upon reconvening the training the class moved onto handcuffing techniques.
- The training concluded at 3 pm.
- The injured officer stated that she had soreness in both shoulders, with the left shoulder being sorer than the right one. Soreness is commonly expected after this training. The officer did not report anything to the instructor, training Sgt. or department supervisors.
- After several days, the injured officer was unable to bend her left arm and began complaining of tightness in her shoulder. Any movement increased the pain.

- Continued next page



- The injured officer contacted her primary care physician who referred her to an orthopedic group.
- The orthopedic doctor issued significant work restrictions and ordered several tests, including an MRI.
- After seeing the orthopedic doctor, the injured officer notified her supervisor that she was injured during the training and provided the restricted duty notice to her employer.
- The MRI showed that there was a labrum tear in the injured officers left shoulder, which the orthopedic doctor causally related to the torque and repetitiveness of the training in which the officer engaged.

DAMAGES

The claim was ultimately accepted under the CIRMA Member's Workers' Compensation policy.

- The injured officer underwent an initial surgery to repair the torn / damaged labrum.
- The injured officer did not recover well and had significant complications in the healing process, including pain and lack of range of motion post operatively that did not improve.
- The injured officer ultimately underwent a full shoulder replacement and was given permanent restrictions.
- The employer engaged in the interactive process and unfortunately it was determined that the restrictions were beyond the ability for the employer to accommodate.
- The injured officer, her employer and CIRMA entered into a full and final stipulated agreement and resolved the claim for \$563,700; settlement breakdown is as such:
 - ▶ Indemnification - \$421,473
 - ▶ Medicals - \$142,227

CONCLUSION

"The high-risk profession of policing leaves little room for error; therefore, training is critical and should be the top priority of every law enforcement organization," James Burdock, instructor with the FBI's Law Enforcement Officers Killed and Assaulted program.

As a profession, policing presents many dangers to both the police officer and those they encounter during calls for service. However, proper training can help reduce these risks.

To effectively operate, law enforcement members have a responsibility to provide appropriate, up-to-date, and sustainable training, as mandated by Conn. State Law and the Police Officers Standards and Training Council (POST-C). These standards emphasize the importance of law enforcement agencies in maintaining high moral and ethical standards, providing officers with the education and techniques needed to protect themselves and equip them with the knowledge needed to handle combative suspects.

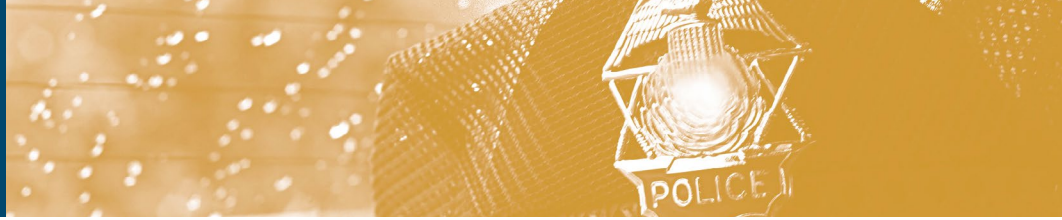
Taking extra steps to provide advanced instruction helps law enforcement organizations to succeed. Proper completion of law enforcement trainings provides protection, reduces risks, and fosters growth for officers, agencies, and ultimately communities.

It does take time, resources, and funding to make law enforcement training possible. However, improper planning and training execution can lead to costly officer injuries during training and in the community.

KEY RECOMMENDATIONS/ACTION ITEMS

To further assist Connecticut law enforcement members in managing the increased exposure surrounding physical training the following recommendations are proposed:

- **Communicate to all officers attending training of any topic changes** - This will assist in making sure that the officers are prepared for the training session and requirements prior to arriving for the class.
- **Consider implementing a Safety Officer at all "hands on" training sessions** – A safety officer is a qualified officer not participating in the training evolution who observes the class as they engage in the physical aspect of any training. This person works directly under and with the instructor or training Sgt. to help manage the risks that officers may be exposed to during the training class with the focus on achieving the expected outcomes of the training.
- **Consider working with the class instructors to slow down hands on physical training scenarios to a safer speed**- Slower movements and increased repetitions can still build the needed muscle memory to utilize these techniques in real life or full speed scenarios.



- **Recommunicate accident reporting procedures and protocols** – The success of the Accident Reporting and Review Program depends on everyone. Employees must report accidents promptly to their supervisors. The Connecticut Workers' Compensation Statute Section 31-294b(a) states;
 - ▶ (a) "Any employee who has sustained an injury in the course of his employment shall immediately report the injury to his employer, or some person representing his employer..."
- **Ensure that injured employees know and understand that they should seek first treatment at the department's Initial Care Provider (ICP)** - When an employee is injured on, or becomes ill from, the job, he or she becomes eligible for a number of statutory benefits. First of these is necessary medical treatment. The most immediate concern in cases of occupational injury or disease is the health and physical well-being of the employee and providing prompt initial care. Because of this, an injured or ill employee is entitled to receive all necessary and appropriate medical treatment. The employer is responsible for furnishing the initial medical treatment at an employer-designated office or facility. (Reference: *Initial Medical Treatment [31-279, 31-279-10, 31-294d]*)

All Connecticut Interlocal Risk Management Agency (CIRMA) inspections and recommendations are purely advisory and intended to assist our members in risk control and safety procedures. The implementation of recommendations made by CIRMA is the sole responsibility of the member. Observations and recommendations of CIRMA are based on practices and conditions observed and information made available to us at the time of our visit, and do not imply or guarantee full compliance with Local, State or Federal regulations that may be applicable to such practices and conditions. These inspections, reports and recommendations do not signify or imply that other hazards do not exist.

Questions on this topic? Ask your Supervisor or CIRMA Risk Management Consultant.

Racial Profiling

OBJECTIVES

The objectives of this large loss claim review are to:

- Examine a recent Law Enforcement Liability (LEL) claim related racial profiling and implicit bias;
- Understand the impact associated with certain discriminatory practices;
- Develop specific risk management best practices to either prevent or mitigate future losses for Connecticut law enforcement agencies based on lessons learned.

BACKGROUND AND INVESTIGATION

- While on patrol during the evening shift in January 2019, a police officer noticed an African American male, wearing a dark “hoodie” and a Hispanic female, also wearing a “hoodie” exit from the front door of their apartment.
- The apartment complex was part of the Public Housing Authority and was known by officers as a “hot spot for drug activity”.
- The housing complex’s racial demographics are as follows:
 - ▶ 52% Caucasian (White)
 - ▶ 25% African American
 - ▶ 20% Hispanic
 - ▶ 3% Asian American
- The two (2) individuals appeared to be between the ages of 20 -25 years old.
- The two (2) individuals approached a newer model Hyundai Santa-Fe, and after cleaning off the snow from the vehicle the male person entered the driver’s side of the vehicle.
 - ▶ There was a recent snow storm that had just concluded, leaving approximately 2-3-inches snow on the ground and on the parked vehicles in the complex.
- After entering the vehicle, the male driver started the SUV, put the vehicle in drive, proceeded to exit the apartment complex and turned onto a main road.
- The officer began to follow the light-colored SUV.
- After approximately 5 minutes, the officer initiated a traffic stop by turning on his emergency warning lights, as well as his siren.
- Upon noticing the police officer with his warning lights on, the driver of the SUV pulled to the right side of the road and lowered the driver’s side window.
- The officer approached the window and asked if the driver knew why he was being stopped, to which the driver replied, “No”.
 - ▶ At this time, the driver had not violated any motor vehicle regulations.
- The officer stated that the area from which the two (2) individuals had just left, was known for drug activity. The officer then asked for identification from both the driver and passenger.
- Both the male driver and female passenger provided the officer with valid state-issued identification. The driver also produced a valid vehicle registration and insurance card.
- The officer took the information and returned to his patrol car where he processed both individual’s information. The officer found there were no active “wants” or issues with their documentation.
 - ▶ The male’s driver license identified the apartment complex as his home address.
 - ▶ The passenger’s license indicated another home address across town.
- The officer returned to the driver’s side window and asked if there was anything in the vehicle that he should know about or that the occupants should not have.
- Both the driver and passenger stated that there was not.
- The officer then asked both occupants to exit the vehicle, at which time the driver asked, “Why?”
- The officer again gave a command to the occupants to exit the vehicle, to which the driver again asked, “Why?”

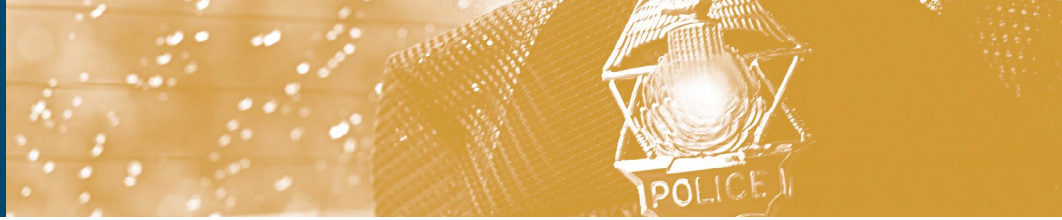
- Continued next page



- The officer opened the driver's door and grabbed the driver's arm and pulled him out of the vehicle.
 - ▶ The driver did not resist when forced out by the officer and again asked, "Why am I being pulled out of the vehicle?"
- The officer stated that he had reason to believe there were drugs in the vehicle and wanted to search the vehicle.
- The driver, also the registered vehicle owner, refused consent to search.
- At this time, the passenger exited the vehicle without force. Both the driver and passenger were asked by the officer to sit on the curb while officer called for a K-9 unit.
- While sitting on the curb, the officer turned on his patrol car's spotlight and shined it onto the driver and passenger.
 - ▶ This illuminated each of their faces so that any person driving by would be able to see them.
- The K-9 Officer arrived on scene and asked again for consent to search the interior of the vehicle, the driver refused.
- The K-9 Officer then had the K-9 conduct an exterior "walk around" of the vehicle. Upon completion of the "walk-around", the K-9 did not "hit" or indicate the presence of any narcotics.
- Upon hearing the K-9 Officer indicate this to the other officer, the driver slowly stood up and calmly asked if he can return to his vehicle.
- At this time the officer began yelling at the driver telling him to get on the ground. After several commands to get on the ground, the driver sat back down on the curb and began to argue with the officer.
- The officer then proceeded over to the driver, asked him to stand up, turn around, and put his hands behind his back. The driver refused and asked for an explanation.
- The officer then pushed the driver against his patrol vehicle and forcibly placed the driver's hands behind his back, ultimately placing him in handcuffs.
- The officer then moved the driver into the back of the police vehicle at which time he stated he was placing him under arrest for interfering with a police officer.
- The driver was transported to the local police station, and the driver's car was released to the passenger on scene.
- The passenger called the driver's parents and explained what had happened and where the driver had been taken.
- Upon arrival at the station, the commanding officer asked what had occurred, as the driver's parents had already called the station asking for an explanation.
- The officer provided his detailed account of the events, including the reason for the initial stop as suspicious activity.
- The officer was wearing a body-worn camera which recorded the events along with the vehicle's dash camera.
- The commanding officer reviewed both videos and determined that there was not any cause for the arrest and released the driver; without any formal charges, to his parents upon their arrival at the station.
- Further review into the officer's actions and history indicated that this officer's motor vehicle stops were predominantly made on African American individuals coming in and out of the same apartment complex.

DAMAGES

- The claim was ultimately accepted under the CIRMA Liability-Auto-Property (LAP) policy.
- The driver and passenger retained legal counsel and filled a law suit against the officer, the department and town alleging;
 - ▶ Discriminatory practices against people of color,
 - ▶ Deformation of character,
 - ▶ Emotional distress,
 - ▶ Negligent supervision of the officer,
 - ▶ Negligent retention of the officer, and
 - ▶ Failure to maintain adequate training.
- The total demand made by the plaintiffs was \$2 million dollars.
- After reviewing the video, securing depositions of all parties involved, and review of the department's enforcement demographics, along with the media attention to this incident, it was determined that this case was best suited for a settlement strategy.
- Negotiations extended several months, however, they ultimately concluded in an agreed settlement amount of \$950K plus attorney fees and expenses.



CONCLUSIONS

Law enforcement and municipalities are among the many segments that have dealt with significant tumult this past year, but in their case, it's not completely related to the pandemic. Rather, the deaths of Black citizens by white police officers sparked racial justice movements across the country and shined a light on unjust police practices.

The legal doctrine known as qualified immunity has worked as a liability shield against frivolous litigation in suits against police officers and the municipalities they work for by making it difficult for plaintiffs to prove excessive force. But after so many high-profile events, qualified immunity has come under scrutiny in the courts, with even some judges questioning its application in excessive force cases. If liability claims against police departments or municipalities succeed, often there are associated large financial settlements, and loss of public trust.

Police departments nationwide are under a microscope and compelled to address racial biases within their force. Policies like police immunity when shootings occur and civil rights violations are being more heavily scrutinized and litigated, with multi-million-dollar settlements in some cases.

For the first time in its 27 years of measuring attitudes toward the police, Gallup found that a majority of American adults do not trust law enforcement. Amid waves of civil unrest as protesters across the country continue to demonstrate against police brutality, Americans' confidence in the police has dropped to a record low, according to a Gallup poll¹. This decline in trust not only affects the community, but also affects officer safety, the department's reputation and can create long term implications to the overall operations, and management of a department.

KEY RECOMMENDATIONS/ACTION ITEM

To further assist Connecticut law enforcement members in managing the increased exposure surrounding racial profiling allegations the following recommendations is proposed:

Provide effective training in accordance with the Conn. Police Accountability Act - The Connecticut General Assembly convened in a special session to consider a comprehensive police accountability bill in response to a call to action following the death of George Floyd and the ongoing Black Lives Matter movement. On July 30, 2020, the bill passed the General Assembly and the Governor signed it into law one day later.

The law amends Section 7-294s of the Connecticut General Statutes ("State and local police training programs to provide training in the use of physical force and body-worn recording equipment and *cultural competency and sensitivity training*").

Currently, police officers are required to undergo training on the use of physical force, the use of body-worn recording equipment, and cultural competency and sensitivity and bias-free policing. The amendment modifies the scope of this training to include "implicit bias training."²

¹ <https://www.nytimes.com/2020/08/12/us/gallup-poll-police.html>

² <https://www.jacksonlewis.com/publication/Connecticut-requires-implicit-bias-training-police>

All Connecticut Interlocal Risk Management Agency (CIRMA) inspections and recommendations are purely advisory and intended to assist our members in risk control and safety procedures. The implementation of recommendations made by CIRMA is the sole responsibility of the member. Observations and recommendations of CIRMA are based on practices and conditions observed and information made available to us at the time of our visit, and do not imply or guarantee full compliance with Local, State or Federal regulations that may be applicable to such practices and conditions. These inspections, reports and recommendations do not signify or imply that other hazards do not exist.

Questions on this topic? Ask your Supervisor or CIRMA Risk Management Consultant.

Implicit Bias

OBJECTIVES

The objectives of this large loss claim review are to:

- Examine a recent Law Enforcement Liability (LEL) claim related to profiling and implicit bias;
- Understand the impact associated with certain discriminatory practices;
- Understand the reputational risk faced by departments;
- Develop specific risk management best practices to either prevent or mitigate future losses for Connecticut law enforcement agencies based on lessons learned.

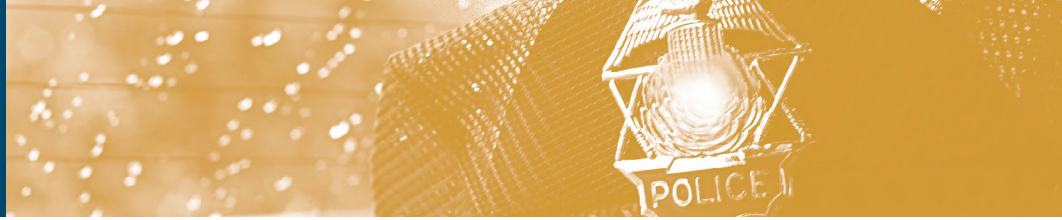
BACKGROUND

On the date of the incident the plaintiff, a Hispanic male, was traveling through the CIRMA-member town when he came across a seat-belt/cell phone check point. One officer “recognizes” the plaintiff as someone who he might have pulled over before, and subsequently directed the plaintiff to pull over to the processing area. The plaintiff was then commanded to exit the vehicle and placed into handcuffs approximately 30 seconds later. The plaintiff was searched, his vehicle was searched, and he was ultimately issued a written warning for having an obstructed view.

The plaintiff hired an attorney and submitted an FOIA request for the body-worn camera (BWC) footage of all officers on the scene. Based on the BWC footage, the plaintiff’s attorney filed a lawsuit against the police department, its officers and the town for discrimination, and unreasonable use of force.

INVESTIGATION

- The member has a current population of just over 10,000 residents.
- The member police department applied for and was awarded grant money to engage in the “Click or Ticket” seat belt enforcement program.
- On the date of the incident the department had set up a “check point” at a four (4) way intersection.
 - ▶ The set up consisted of proper signage indicating that motorist where entering a checkpoint.
 - ▶ Traffic cones where placed in a proper pattern to direct the traffic flow that passed by the officer in the roadway.
 - ▶ There were several police vehicles with their emergency lights activated to identify that law enforcement was in the area.
 - ▶ Officers where in the roadway wearing the required D.O.T. High Visibility clothing.
- At this check point, officers would observe the vehicle enter the “check point” and make a visual determination as to whether or not the operator and any occupants of the vehicle were wearing their seat belts.
 - ▶ In addition, officers would visually determine if the operator was using a hand-held phone device while driving.
- The plaintiff, operator of his vehicle and only occupant, entered the “check point” in a controlled manner and was wearing his seat belt, and was not operating his cell phone.
 - ▶ This was confirmed after review of the plaintiff’s cell phone activity.
- As the plaintiff continued through the “check point” one officer states that he recognized the plaintiff as someone he has pulled over before.
- The officer directs the plaintiff to pull his vehicle over to the processing section, which the plaintiff complies with.
 - ▶ Within the processing area is another vehicle with two (2) white male subjects standing outside of their vehicle talking with another officer.
- Once the plaintiff vehicle is stopped the officer asks the plaintiff to exit his vehicle, which he does.
- The plaintiff puts his hands inside of his pants pockets and is immediately ordered by the officer to take his hands out of his pockets. The plaintiff immediately complies, taking his hands out of his pockets and puts them in the raised “surrender position”. This is verified through the BWC footage.
- The officer then pushes the plaintiff up against the car and places him in handcuffs.
- When asked by the plaintiff why he is being handcuffed and why he was “pulled over” the officer replies that he has an

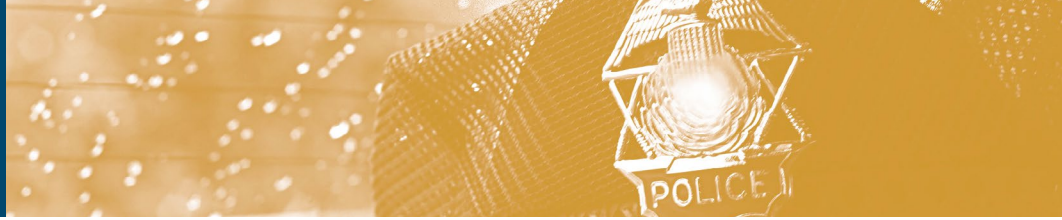


obstructed view through his front windshield, and that is illegal. The officer states that the plaintiff failed to comply with his verbal commands – keep your hands out of your pockets.



- The plaintiff, a Hispanic Male, was then leaned over the hood of the near by police vehicle and searched.





- The officer then called for a K9 Officer, who was already onsite to gain consent from the plaintiff to search his vehicle, frustrated and just wanting to leave, the plaintiff answered all of the K9 officer's questions and gave consent for the K9 officer to search his vehicle.
- The police dog **did not indicate** as to the presence of any illegal drugs and was subsequently returned to the K9 officers' vehicle.
- The Officer then conducted a physical search of the vehicle, which **did not yield** any evidence of illegal substances or activity.
- The plaintiff was un-cuffed and allowed to enter his vehicle.
- Once in his vehicle, the plaintiff was asked by officers for his license, registration, and proof of insurance. The plaintiff asked why the officer just did not take that from him while he was searching the vehicle.
- The officer at this time states, "Are you going to give it to me, or should I arrest you for interfering with a police officer...?".
- The plaintiff provides the information and is issued a written warning for having an obstructed view, caused by one (1) air freshener.

DAMAGES

The claim was ultimately accepted under the CIRMA Liability-Auto-Property (LAP) policy.

The driver and passenger retained legal counsel and filled a lawsuit against the officer, the department and town alleging;

- Discriminatory practices against people of color,
 - ▶ This is based on the BWC footage of the two (2) white males not in handcuffs.
 - ▶ It is noted that both white males were subsequently arrested for illegal possession of a firearm. However, they were not handcuffed and were processed from the scene with a promise to appear agreement.
- Deformation of character,
- Emotional distress,
- Negligent supervision of the officers,
 - ▶ There were high ranking command officers on scene
- Negligent retention of the officer, and
- Unreasonable use-of-force.

The total demand made by the plaintiffs was \$100K dollars.

After reviewing the video, securing depositions of all parties involved, and review of the department's enforcement demographics, along with the media attention to this incident, it was determined that this case was best suited for a settlement strategy.

Negotiations extended several months, however, they ultimately concluded in an agreed settlement amount of \$50K plus attorney fees and expenses.

There was a significant media response to this incident, which resulted in several peaceful protests. The incident resulted in damaged departmental reputation and a sense of mistrust in the community.

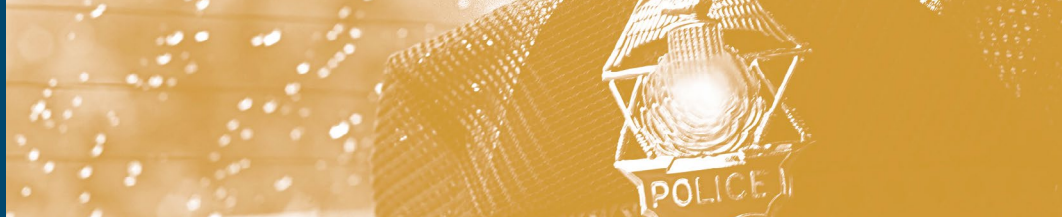
CONCLUSION

Law enforcement and municipalities are among the many segments that have dealt with significant tumult this past year, but in their case, it's not completely related to the pandemic. Rather, the deaths of black citizens by white police officers sparked racial justice movements across the country and shined a light on unjust police practices.

The legal doctrine known as *qualified immunity* has worked as a liability shield against frivolous litigation in suits against police officers and the municipalities they work for by making it difficult for plaintiffs to prove excessive force. But after so many high-profile events, qualified immunity has come under scrutiny in the courts, with even some judges questioning its application in excessive force cases. If liability claims against police departments or municipalities succeed, often there are associated large financial settlements, and loss of public trust.

Police departments nationwide are under a microscope and compelled to address racial biases within their force. Policies like police immunity when shootings occur and in civil rights violations are being more heavily scrutinized and litigated, with multi-million-dollar settlements in some cases.

For the first time in its 27 years of measuring attitudes toward the police, Gallup found that a majority of American adults do not trust



law enforcement amid waves of civil unrest as protesters across the country continue to demonstrate against police brutality, Americans' confidence in the police has dropped to a record low, according to a Gallup poll¹. This decline in trust not only affects the community, but also affects officer safety, the department's reputation and can create long term implications to the overall operations, and management of a department.

COMMITTEE ACTION

Currently, police officers are required to undergo training on the use of physical force, the use of body-worn recording equipment, cultural competency and sensitivity, and bias-free policing. The amendment modifies the scope of this training to include "implicit bias training."²

CIRMA Risk Management is seeking feedback from the Law Enforcement Advisory Committee on the recommendations to reduce injuries from occurring during physical trainings. Following the meeting, any additional thoughts or comments should be directed to Joey Barbera (jbarbera@ccm-ct.org).

¹ <https://www.nytimes.com/2020/08/12/us/gallup-poll-police.html>

² <https://www.jacksonlewis.com/publication/connecticut-requires-implicit-bias-training-police>

All Connecticut Interlocal Risk Management Agency (CIRMA) inspections and recommendations are purely advisory and intended to assist our members in risk control and safety procedures. The implementation of recommendations made by CIRMA is the sole responsibility of the member. Observations and recommendations of CIRMA are based on practices and conditions observed and information made available to us at the time of our visit, and do not imply or guarantee full compliance with Local, State or Federal regulations that may be applicable to such practices and conditions. These inspections, reports and recommendations do not signify or imply that other hazards do not exist.

Questions on this topic? Ask your Supervisor or CIRMA Risk Management Consultant.

Failure to Train

OBJECTIVES

The objectives of this large loss claim review are to:

- Examine a CIRMA Liability-Auto-Property (LAP) loss resulting from claims about law enforcements failure to train.
- Discuss CIRMA's and other resources on reducing liability associated law enforcement training,
- Develop specific risk management best practices to either prevent or mitigate future losses for members based on lessons learned.

INCIDENT BACKGROUND

On the date of the incident, the claimant was driving his newer model Ford Explorer when he “rolled” through a stop sign. The officer observed this infraction and initiated a traffic stop, activating his emergency warning lights and siren. The driver pulled his vehicle to the side of the road after noticing the activated emergency lights. The plaintiff opened his window and placed his arms outside of the vehicle, with his hands in the open position. The officer exited his marked police vehicle yelling to the plaintiff to stay in the vehicle. As the officer approached the vehicle he continued to yell commands at the plaintiff, who did not respond. After several requests, the officer became frustrated and ordered the driver out of the vehicle. The driver did not comply and was pulled out of the vehicle by the officer and thrown to the ground. While the plaintiff was on the ground with his hands behind his back, the officer continued to yell at the plaintiff asking him, “who he thought he was”. Upon impact with the ground, the driver struck his face breaking 2 teeth and also sustained a laceration to his chin.

INVESTIGATION

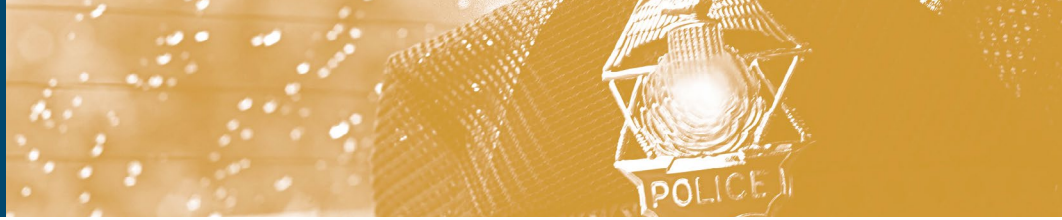
- The plaintiff is a 26-year-old male who is deaf in both ears.
- The plaintiff stated that he placed his hands out side of the window as precaution so that the officer did not think he was reaching for a weapon. His intent was to grab the note pad on the passenger seat to communicate to with the officer.
- The plaintiff stated that he tried telling the officer “No Ears”. Meaning that the plaintiff could not hear the officer’s commands.
- While on the ground, the plaintiff attempted to use sign language to communicate however, the officer perceived this as resisting behaviors and continued to yell at the plaintiff.
- Once the plaintiff was put in the seated position it was observed by the officer that he was bleeding from the chin and mouth. The officer at this time requested Emergency Medical Services (EMS) to respond to the scene.
- EMS arrived on scene and began to treat the plaintiff for his injuries.
- EMS determined fairly quickly that the plaintiff was deaf and needed to communicate through writing or American Sign Language.
- The plaintiff was transported to the hospital where he received initial treatment for his laceration and broken teeth.
- The plaintiff was referred to an oral surgeon, to whom he followed up with.
- The officer filed charges against the plaintiff ranging from resisting a police officer, failure to stop, failure to obey a traffic control device and disturbing the peace.
- All charges were eventually dismissed.

INJURY AND DAMAGES

As a result of this incident, the plaintiff suffered the following injuries:

- Two (2) broken teeth requiring further oral surgery to extract and place permanent implants
- A laceration to the chin requiring 5 sutures to close, resulting in permanent scarring;
- Ongoing anxiety

The plaintiff filed their notice of intent to sue, with an initial demand of damages for \$150K. After successful pre-trial negotiations, this claims settled for \$75K.



CONCLUSION

At some point during an officer's law enforcement career, they may need to communicate with a deaf or hard-of-hearing person during the course of their duties. According to the National Institute on Deafness and Other Communication Disorders¹, approximately 2% of adults between the ages of 45 and 54 have disabling hearing loss. The rate increases to 8.5% in adults between the ages of 55 and 64. For those between the ages of 65 and 74 the disabling hearing loss rate increases to nearly 25% while for those who are ages 75 and older, the rate can reach 50%. The same report notes that about 28.8 million Americans could benefit from using hearing aids.²

Knowing that 1 out of 20, or as many as 1 out of 10, people in the United States may have a hearing disorder, is the law enforcement community doing enough, or anything at all, to assure that members of the deaf community are receiving a comparable level of service to those that are not hearing impaired?

To address this topic, the U.S. Department of Justice (DOJ) has reviewed the American with Disabilities (ADA) Act and how it relates to law enforcement, and has published a guide for law enforcement agencies. The guide includes recommendations on how to best serve the deaf community and how to comply with the Americans with Disabilities Act. The guide from the U.S. DOJ is entitled *Communicating with People who Are Deaf or Hard of Hearing: ADA Guide for Law Enforcement Officers*. The guide discusses the requirements per ADA, provides recommendations for law enforcement agencies and how to comply with those requirements, recommends training for individual officers, and provides scenarios to illustrate what actions may be appropriate for a given situation.

People who immediately exit their vehicle during a traffic stop, whom have sudden and rapid hand movements and are reaching into a pocket to retrieve a notepad (or possibly a weapon in the officer's mind) are all actions that can immediately cause concern for a police officer. Since police officers want to provide the highest level of service possible to all members of the community, a little training, preparation and understanding, will help to reduce the likelihood of this type of situation arising and resulting in an officer's use-of-force and lead to positive interactions between the officer and members of the deaf community.³

KEY RECOMMENDATIONS/ACTION ITEMS

CIRMA Risk Management team is seeking feedback from the Law Enforcement Advisory Committee on the recommended best practices to prevent these incidents from occurring.

- Providing training to officers on how to recognize signs associated with those whom have difficulty hearing or are deaf.
- Provide training to officers based on the recommendations contained in U.S. DOJ publication entitled *Communicating with People who Are Deaf or Hard of Hearing: ADA Guide for Law Enforcement Officers*.
- Consider providing officers with basic American Sign Language (ASL) signs to attempt to communicate with a person when a threat is not present.

¹ <https://www.nidcd.nih.gov/health/statistics/quick-statistics-hearing>

² <https://blogs.cdc.gov/publichealthmatters/2022/03/asl-glossary/>

³ <https://www.lifeprint.com/asl101/topics/lawenforcementandthedeaf.htm>

Questions on this topic? Ask your Supervisor or CIRMA Risk Management Consultant.

All Connecticut Interlocal Risk Management Agency (CIRMA) inspections and recommendations are purely advisory and intended to assist our members in risk control and safety procedures. The implementation of recommendations made by CIRMA is the sole responsibility of the member. Observations and recommendations of CIRMA are based on practices and conditions observed and information made available to us at the time of our visit, and do not imply or guarantee full compliance with Local, State or Federal regulations that may be applicable to such practices and conditions. These inspections, reports and recommendations do not signify or imply that other hazards do not exist.
