

# Use of Force Analysis

related to the death of

## **Jamal Sutherland**

in the

Sheriff Al Cannon Detention Center

Charleston County Sheriff's Office

Charleston, South Carolina

July 24, 2021

**Gr\*A\*R, Inc.**  
CRIMINAL JUSTICE CONSULTING

July 24, 2021

Solicitor Scarlett Wilson  
Ninth Circuit Solicitor's Office  
Charleston, South Carolina

Solicitor Wilson:

You have asked for opinions on generally accepted jail practices as they pertain to the tragic death of Jamal Sutherland. There was ample evidence in this case for me to confidently form those opinions and reach conclusions as to whether the actions, policy, training, supervision and general practice of the Sheriff Al Cannon Detention Center (SACDC), and its employees, conformed to standards and generally accepted jail policy, training and practices regarding the death of Jamal Sutherland. Additionally, there was ample evidence regarding the effect of these matters on the involved deputies.

I have relied upon my education, training and experience to form these opinions, which includes:

- 31 years in a career with the Ada County Sheriff's Office in Boise, Idaho where the jail was similarly sized to the SACDC.
- 10 years as the elected sheriff Ada County, Idaho.
- 7 years serving as a US Attorney General's appointment to the National Institute of Corrections – the leading federal agency in corrections policy and practice.
- Appointments by two federal courts to monitor Consent Decrees in jails regarding the unreasonable use of force.
- Master's degree in criminal justice administration from Boise State University
- Graduate of the FBI National Academy, FBI National Executive Institute, FBI Law Enforcement Education and Development Seminar, FBI Command College, Northwestern University School of Police Staff & Command, National Sheriffs Institute and others.
- Analysis and review of over 50 controversial incidents across the United States, mostly involving the use of force and in-custody deaths.

It is important to know that beyond the statutes and codes, there are no compulsory standards for jails in the United States. For this analysis, I have, first and foremost, relied upon US Supreme Court decisions that have helped define reasonable, and unreasonable, force in jails. Beyond that, I have most often relied upon *generally accepted jail practices*, or those practices that are established and accepted as proper within the jail industry. Also, where applicable, this analysis incorporates accreditation standards and best practices from organizations like the American Jail Association, American Correctional Association and National Commission on Correctional Health Care.

As with most states, South Carolina has “Minimum Standards for Local Detention Facilities in South Carolina”; however, also like most states, those standards are mostly administrative and discuss living conditions, reporting procedures and the requirement to have policies, but not what those policies should say. There are no South Carolina Jail Standards for compelling court appearances, de-escalation and force avoidance practices, cell extractions or the proper use of chemical agents, the TASER device or other use of force tactics and practices. Unfortunately, this absence of guidance is common.

Training standards, especially those from a manufacturer, are additional considerations for whether the use of a weapon was appropriate or not. For example, Axon Enterprises Inc., the company that produced the TASER, provided limited guidance as to the frequency, duration and risks of simultaneous TASER exposure. Those are also incorporated in this analysis.

## Summary

In about 2008, the Charleston County Sheriff's Office (CCSO) made the decision to contract tactical training for the jail to a vendor who taught highly aggressive tactics. The evidence shows the CCSO believed they were having too many staff and inmate injuries during forcible cell extractions with their existing tactical team and the vendor promised to reduce those.

The vendor renamed the SACDC tactical team the *Special Operations Group* (SOG) and brought them tactics that emphasized the use of weapons and intimidation to gain compliance from detainees.

The SOG operated under this outsourced training until about the end of 2018 when the SACDC became unsatisfied with the vendor's practices and behaviors. The training contract ended and in 2019 the SACDC began providing the training with internal instructors. The aggressive tactics and the presence of weapons continued.

By the time of the event with Sutherland, the practice of the SACDC was that only SOG members were to be involved in forcible cell extractions. However, the number of SOG members had dwindled and there were often only one or two people available each shift.

Additionally, the custom and practice of the SACDC was to forcibly compel a detainee's attendance at any Bond Court hearing even though that violated SACDC policy.

On January 4, 2021, Jamal Sutherland was arrested at the Palmetto Lowcountry Behavior Health facility in North Charleston for striking a staff member. Sutherland was taken to the SACDC for booking but was uncooperative. He was placed into an isolation cell in the Behavioral Management Unit.

On January 5, 2021, at about 9:00 AM Sutherland was scheduled to appear in Bond Court but he refused to cooperate. The on-duty jail commander followed the long-standing custom and practice that Sutherland should be forced to appear in Bond Court in person. Deputy Brian Houle was the only SOG member on duty so he was summoned to help. Houle asked Sergeant Lindsay Fickett to help because she had several years of experience in SOG, even though she had left the team when she was transferred to a housing assignment in about October 2020.

Sutherland continued to refuse to submit to handcuffing, so Fickett and Houle eventually used oleoresin capsicum (pepper spray), their electronic control weapons (commonly referred to as a TASER) and physical force to help gain control of Sutherland. After an intense struggle, Fickett and Houle were able to control Sutherland, handcuff him and bring him out of the cell. As they began putting him into an emergency restraint chair, they noticed he was unresponsive. Medical staff were present and provided treatment, but Sutherland died.

This analysis relied upon evidence obtained from the CCSO, the South Carolina Law Enforcement Division (SLED), the Federal Bureau of Investigation and Axon (TASER).

It is worth noting that the CCSO apparently had great difficulty locating and producing much of the evidence in this case, causing significant delays. Additionally, there was a considerable amount of evidence that would have been available and considered in most cases but was apparently not retained and available from the CCSO.

## Summary of Major Conclusions

Fickett and Houle's actions contributed to the death of Sutherland. However, the SACDC customs, practices, training, and lack of policy and capable supervision were significantly responsible for the situation itself and the actions the deputies took. The most tragic finding is that this event was unnecessary and only happened because of the failures of leadership in the SACDC.

Specific findings:

1. The SACDC had adopted dangerous and unproven tactics for cell extractions.
2. The SACDC failed to adequately train staff in mental health awareness and practices.
3. The SACDC failed to provide a sufficient number of deputies to safely conduct a cell extraction.
4. The SACDC failed to train and reinforce de-escalation techniques to avoid the use of force.
5. The SACDC commander ordered Sutherland to be forcibly taken to Bond Court without cause and in violation of SACDC policy.
6. The SACDC failed to adequately train staff on waiting periods after the use of OC.
7. The SACDC failed to adequately train staff on limiting the number of TASER deployments by a single individual and precautions against simultaneous deployments.
8. The SACDC failed to adequately train staff on the precautions against compressional and positional asphyxia.
9. The SACDC had an unreasonable custom and practice of always putting a spit hood over the head of someone who had been the subject of force.
10. The SACDC ranking staff failed to adequately supervise the line staff, allowing customs and practices that were dangerous and in violation of SACDC policies.
11. The SACDC failed to establish proper policies that governed weapons and uses of force.

## **History of SACDC's Tactical Response Team**

The contemplation of criminal charges against Fickett or Houle should consider how the deputies were trained, supervised and governed by policy. While the following does not directly relate to the events of January 5, 2021, it is very relevant as to how Fickett and Houle came to be in the incident and what the SACDC custom and practice was.

Lieutenant Tyrone Shaw had long been involved in SOG and was one of the key leaders throughout the vendor's contract and then when the SACDC took charge of their own training. He said that prior to about 2008, the SACDC used five-person deputy teams for forcible cell extractions, but staff and detainee injuries were frequent. There was no evidence in the record that showed the numbers of injuries SACDC was experiencing. There was also no evidence of their tactics to know if poor training may have contributed to the injuries. Four to six person teams are common for jails the size of the SACDC and most operate with only a minimal frequency of injuries to staff or detainees.

### **Contract with Untested Vendor**

In about 2008, SACDC Chief Willis Beatty contracted with a private vendor, to redesign the training and tactics for the SACDC tactical response team. There was no evidence as to why the vendor was chosen or what his qualifications were. The vendor renamed the Emergency Response Team the Special Operations Group (SOG). The training sought to form a specialized group of deputies that would serve as a full-time tactical team within the jail. SOG members were called "operators" rather than deputies and wore tactical clothing, including loadbearing vests. They also adopted a practice, unheard of in most jails, that the SOG members routinely carried tactical 12-gauge shotguns loaded with less lethal munitions, regardless of whether there was an immediate need for them or not. Probably most significant to this event, the vendor changed the number of deputies involved in an extraction to only two, and sometimes one.

It is highly unusual for a jail the size of Charleston County to have a full-time tactical team and it is virtually unheard of for anyone to routinely carry firearms inside a jail. The SACDC website reports a physical capacity of 1,693 detainees. Most jails of this size have a tactical team but call on them as needed from the ranks of deputies who are otherwise involved in routine duties such

as supervising housing units, intake processing, transportation, etc. When called upon, those deputies often don protective gear and obtain equipment and weapons as needed. The only evidence about the frequency of violence or resistance in the SACDC was that on average there was a cell extraction every few weeks to few months. This is consistent with similarly sized jails and does not explain the need for the SOG.

The vendor began teaching aggressive tactics, emphasizing the use of weapons and physical force. The evidence included verbal and printed statements emphasizing humane treatment, force avoidance and similar practices, but the evidence did not show that those practices were part of the curriculum. In fact, the evidence suggests just the opposite – that the SOG was taught aggression and intimidation as a way to avoid resistance.

The SACDC did not possess or retain any of the training objectives or lesson plans for the SOG training. In fact, it appears the only written materials used for training was a schedule and PowerPoint slides, but the students were not given copies of the slides. According to Shaw, the vendor claimed his training materials were “classified”. Furthermore, there was no policy, written procedure or testing to select and certify SOG deputies. Certification was solely at the discretion of the vendor.

Failing to review, approve and retain records of training, especially high-liability training, violates generally accepted law enforcement practices. It is critical for an agency to know what their deputies are being taught and as will be explained in more detail, the absence of that in the CCSO is shocking. It is also important to provide reference material to trainees and the SACDC failed to do so.

As evidence of the SOG training trickled in from the CCSO for this analysis, the SACDC practices became more and more concerning. Three videos emerged, likely from around 2011 of the vendor leading training sessions where two deputies, one being Fickett, were the subject of what can only be called hazing. Six other SACDC deputies were also present and appeared to be the existing SOG team, or part of it. In the first video the vendor refers to himself as a “Senior Team Leader” and appears to narrate for the benefit of the video camera saying they were going to test the candidate’s ability to deal with stress. He went on to explain that there would be an oleoresin capsicum (OC), commonly known as pepper spray, exposure to simulate a potential event in the



jail when a SOG operator may not be able to don their gas mask. The vendor said it was to make sure the candidate would be able to have good use of force decision-making and to see if they could maintain their mental composure and professionalism under stress.

The second video clip (a screenshot shown at right) began about 45 minutes later and showed Fickett, already doused in OC, as the vendor shouted questions and “whooped” loudly while emptying two riot control-sized canisters of OC at her. During this, there was nothing that would demonstrate any test of her use of force decision making



or anything other than the tolerance of unnecessary pain and discomfort. This excessive OC exposure did not meet any legitimate jail training objective, nor did it accomplish what the vendor said it was intended for.



The third video clip started a few minutes later with someone narrating that each of the two candidates (Fickett and another) had by then been exposed to two grenades (presumably OC), and six canisters of OC. Both candidates were then brought back before the group. It is clear that both were in distress from the immense amount of OC to which they had been exposed.

Some of the deputies present told the candidates they should quit, but they refused. Again, this was clearly a hazing exercise and had no legitimate training purpose. The vendor gave each of the two a fresh canister of OC and had them face off at each other. He then asked them a series of questions and, per his instructions, they replied by yelling, “No, I will not!” while discharging the

OC canister into the other candidate's face. Once those canisters were empty, the vendor sprayed three more canisters into the faces of the candidates.

I do not have sufficient words to describe how ridiculous this was. The unnecessary and excessive exposure to OC can cause respiratory, skin, eye and other medical issues. I am not versed in South Carolina's hazing, torture, assault and similar statutes, but the vendor's actions may have amounted to criminal conduct.

While some of the vendor's verbalizations and written statements emphasized force avoidance, there was no evidence of meaningful de-escalation or avoidance training in the SOG training. Fickett later said SOG training was a lot of physical work – carrying things, lifting things, running, tactics, weapons manipulation and some “combatives.” She said they were pepper sprayed once a week or more when the vendor ran the training. She was also clear that there was no meaningful SOG training on de-escalation techniques, even when she later became an SOG instructor. A training flyer from the vendor's company for a 5-day SOG course listed 17 training topics but none were related to de-escalation or force avoidance.

Two documents in the evidence appeared to be PowerPoint slide printouts from the vendor's training. There was no indication of the timeframe the slides were created or used – or if they were even used to train SACDC deputies. When compared against generally accepted jail training practices, the PowerPoint slides were seriously insufficient to instruct and direct deputies how to avoid the use of force, judge when and how much force to use, or how to recognize unreasonable force, etc. Examples include:

- The slides included broad, sometimes confusing statements, like “However, operational pause should be given when consideration about using the necessary force on in [sic] inmate.”
- In the slides addressing mentally ill detainees, the instruction discussed various weapons to use but failed to address when they are appropriate.
- Some slides provided clinical explanations or behavioral patterns of mental health disorders, while another slide entitled “Profiling Inmates” seemed to suggest deputies should identify whether a detainee is bipolar, schizophrenic, has “manic depressive disorders” or is “mentally retarded.” I am not qualified to evaluate the psychological

accuracy of the vendor's slides, but generally accepted correctional training recognizes that deputies are not qualified to differentiate these disorders. Moreover, the terminology used is clearly inappropriate.

At the same time, there were elements of the PowerPoints that were applicable to the event involving Sutherland. Examples include:

- Instruction to know the mental health history of inmates.
  - “When dealing with the mentally ill, we do not resort to using an ECD (Taser) without first offering options, issuing commands and when safe or reasonable, attempting physical skills.”
  - Regarding mentally ill detainees: “Extreme caution should be given when attempting to use physical control techniques. Mentally ill inmates have a tendency of posing a high level of pain tolerance and have demonstrated extra human strength.”
- Instruction to be aware of an inmate's situation.
  - “Reframe [sic] from using OC to gain compliance as it will only exacerbate the situations further.”
  - “Inmates that have been exposed to OC have a propensity not to listen to verbal instructions as they are pushed further into a mental state.”
- Direction for conducting dynamic cell extractions.
  - “Have multiple plans worked out.”
  - “Don't be afraid to reset, close the door and re-access [sic].”

In the document, there were about 17 pages labeled *Student Handout & Study Guide* however many of the pages contained no instructional information and the testimonial evidence showed the students were not provided any handout materials.

### **In-house SOG Training and Tactics**

By 2018 the vendor's reputation and business practices had come into question. Four SOG members wrote statements about the training. The complaints centered on the vendor's bias, poor training of new recruits, use of CCSO time and personnel for personal marketing materials and

serious inconsistencies in training. A senior SOG leader wrote, “The command staff have been aware of all these issues with trainings, his uncontrollable canines attacking officers, his language etc. for some years now. It has placed a serious drop in morale on the SOG team. It has even hindered the amount of new officers willing to come out to training because they know that they will have to bear the burden of dealing with the inconsistencies that come with [the vendor] and SOG training.” Another deputy wrote, “Many of the command staff who would stay in the trainings for minutes, we felt would not stay or attend for long because many of the trainings did not fit the policy of this detention center. So why then, where [sic] the staff of this detention center being placed under such a strain? Placed under a training program that would not be utilized and went against the policy of the detention center.” The deputy went on to say, “SOG operators were basically told by command staff after [the vendor’s] trainings were over, forget what he has trained and stick to policy. That has placed a strain on Operators.... [the vendor] is known for directing an operator to go tactical one-way and five minutes to an hour later he will tell another operator that’s not the way he wants it done.”

The contract between the CCSO and the vendor ended sometime in early 2019 and CCSO brought the training in-house. By this time, Shaw had been promoted to lieutenant and Fickett had been promoted to sergeant, and they took primary responsibility for revising and delivering the new, in-house, SOG training. Much of the philosophy and confrontational tactics carried over into the new training; however, Fickett said that much of the vendor’s training “...was more extreme than what our policy allows” so they aligned it more closely with CCSO and SACDC policy. Still, no one created any standardized objectives, lesson plans or training handouts that documented what was taught and ensured consistency between SOG members. Fickett said that when policies changed that affected SOG operation, they would simply adopt them by word-of-mouth.

When recently asked about de-escalation training, Fickett said, “From the amount of time that we had and the amount of stuff that we had to cover, and none of us are really de-escalation trainers, and we just didn’t even think to add it in. It was like, we have so much time for this much topics, it wouldn’t — didn’t even cross our mind at all.”

The training practices used by the SACDC seriously failed to conform with generally accepted jail practices. While more will be discussed on the topic later in this report, the evidence shows

significant deficiencies for dealing with the mentally ill, de-escalation practices, tactics and safety and the actual applications of force. While it appears the SACDC envisioned a highly trained and competent tactical team, the evidence in this case demonstrates insufficient staffing, training and supervision and a fundamental lack of competency. SACDC sanctioned and continued rogue practices with the SOG training and failed to address policy violations and poor practices. This is indefensible and a fundamental cause of why the events unfolded prior to Sutherland's death.

## **Analysis and Opinions Specific to the Death of Sutherland**

*In June 2021, Fickett cooperated with the Ninth Circuit Solicitor's Office and submitted to an interview wherein she provided significant details about these events. The purpose of the interview was to gain information that was otherwise not included in the interviews and reports. Her statements are not admissible in a criminal prosecution but are included here as they are critical to understanding the actions and decisions of January 5, 2021.*

*Some statements have been edited for readability, such as removing verbal pauses, but the context has not been changed.*

### **Arrest and Bond Court**

On January 4, 2021, Sutherland and another person were arrested after an assault incident at The Palmetto Lowcountry Behavioral Health facility. The evidence showed that the officers of the North Charleston Police Department wisely tried to avoid the physical arrest of Sutherland but the Palmetto Lowcountry Behavioral Health staff "were adamant" that Sutherland be arrested. It is not unusual for behavioral health patients to become assaultive but contemporary police practices seek to avoid the incarceration of a mentally ill person. In this instance it appears the arrests could not be avoided.

During intake, Sutherland was continuing to demonstrate noncompliant behaviors and a mental health request was made at 10:23 PM. The intake process was not completed at that time and Sutherland was placed in the Behavioral Management Unit, a housing unit of individual cells typically used for disciplinary isolation.

In the early morning hours of January 5, 2021, Sutherland was given his breakfast tray and spoon. After breakfast, he refused to return the tray and spoon to jail staff.

At about 9:00 AM, Sutherland was scheduled to appear in Bond Court. Bond Court was held via videoconferencing with the detainee remaining within the jail but appearing from a room specifically configured with the audio/video connection. Sutherland refused to voluntarily submit to handcuffing so he could be taken there. Lieutenant Bryan Duvall and Sergeant Christopher Fennel learned of Sutherland's refusal and went to the Behavioral Management Unit. Duvall later

reported that Sutherland was verbalizing conspiracies and “random stuff”. Each time they asked Sutherland to come to the door, he would refuse and challenge them.

SACDC staff, mostly Sergeant Fennel, spent 10 to 15 minutes trying to gain Sutherland’s cooperation to appear in Bond Court. Fennell said Sutherland was saying a lot of things that did not make sense and appeared to be mentally ill. He also said Sutherland was saying, “Kill me, I want to die.” during their conversation and he saw Sutherland holding the plastic spoon that Fennell thought may have been filed down to make a weapon. Toward the end of the conversation, when Sutherland was ordered to come to the door, he walked to the back of the cell and said, “Pop the pin.”

Brian Houle was the only SOG member on duty and was summoned in anticipation of a forcible cell extraction. After learning of the situation, Houle called Fickett and asked if she could assist him because Fickett had been a member of SOG for several years but had been reassigned to be a housing sergeant in October 2020.

Houle later reported that there had been instances of a detainee being rescheduled for Bond Court appearance when it appeared they were going to be violent. Houle said that he voiced his concern to Duvall about using force on Sutherland to compel the attendance and he overheard Duvall having conversations to try to delay Sutherland’s Bond Court appearance.

In Houle’s interview by SLED on January 15, 2021, he was questioned:

- **Q:** So, for the Sutherland extraction, you've voiced your concern to your chain of command?  
**Houle:** “Absolutely.”
- **Q:** Okay. And, to your knowledge, they followed up with court and voiced—and relayed your concerns? **Houle:** “Yes.”
- **Q:** And they relayed back, basically, you still got to get him to Bond Court? **Houle:** “Yes. That's when my lieutenant called the captain, the commanding—the CDO who was on that week, which was Captain Greathouse, and briefed her on what was going on. And, from what—basically, like in a nutshell, what I gathered is she said, 'Judge wants to see him, so bring him down there. Whichever way you have to.'”

During his interview, Lieutenant Shaw said there had been many times when SOG deputies had pushed back on performing cell extractions when it may have been unsafe. Shaw's personal practice was to ask the captain on duty to come to the cell block to see the situation. There were many times the captain would then call the judge and get the hearing rescheduled.

Deputy Tamisha James was the Bond Court deputy on January 5. She said Duvall contacted her and asked if Sutherland had to attend a bond hearing. James said that, per Captain Emma Salters' directive, all inmates had to appear before the judge. She was aware of this from both Captain Salters verbal orders and her knowledge of an email from 2017 that directed it. She even recalled a separate incident in December 2020 when she had postponed an appearance to avoid the use of force and Captain Salters told her that all inmates must attend Bond Court in person.

The CCSO Office of Professional Standards (OPS) later reported that Houle, "spoke with Lieutenant Duvall about his concerns for performing a cell extraction with inmate Sutherland. Lieutenant Duvall stated Deputy Houle did speak with him and brought up several issues. Lieutenant Duvall explained Deputy Houle was the only Special Operations Group team member working that day and inmate Sutherland was combative. Lieutenant Duvall also stated Deputy Houle advised inmate Sutherland was a big man and had access to weapons (spoon/spork and breakfast tray) in his cell." Lieutenant Duvall contacted the Bond Court deputy who told him that Sutherland's appearance in front of the judge was mandatory. Lieutenant Duvall made a second call to determine the origin of the order and Deputy James told him it was Captain Salters. Duvall then tried to call Captain Salters but was unable to reach her. He then contacted Captain Kerry Lynn Greathouse who was the Command Duty Officer (highest ranking on-duty staff member) that day. Duvall later said in his interview, "When I contacted Bond Hearing, they said they were operating under Captain Salters' directive to bring the subject before the judge to refuse Bond Hearing in front of the judge. And when I called Captain Greathouse I told her what the scenario was and she suggested you should bring him down in ERC, emergency restraint chair. I knew there was no other option but to do a cell extraction."

On the body-worn-camera recording, Duvall briefed Fickett and Houle, saying that Greathouse had been notified, the judge had been notified and Sutherland needed to be in court.



Captain Greathouse later reported that she was contacted by Lieutenant Duvall at 9:28 AM and again at 9:57 AM. Captain Greathouse reported that Lieutenant Duvall told her that Sutherland *had* to go to bond hearing, a slight variation from Duvall’s version. However, Captain Greathouse acknowledged that the custom and practice in the SACDC was to force detainees to physically appear in Bond Court based on the April 2017 email Salters authored at the direction of then Chief Deputy Willis Beatty. It read:

“From this moment forward, when an inmate refuses to go to Bond Hearing, **the first time**, you are instructed to notify your supervisors and contact SOG. They will place subject in the ERC, if necessary, and bring him/her before the Judge **to refuse in person**. You will write an information incident report in JMS (Jail Management System) and notify us when it is done.”

During the interview that followed Sutherland’s death, Captain Greathouse was asked, “Before this incident, there was really no alternative to when an inmate had to go to bond hearing, via remotely or refuse. There was nothing that was available as an alternative, is that fair?” Greathouse responded, “That’s correct.” The next question was, “So, as policy/standing directive, nothing from—from the cell extraction—idea of the cell extraction, the order of the cell extraction was outside the norm, it had taken place for years that way, correct?” Greathouse responded, “Correct.” Salters said it had been the custom and practice since 2017, even though the directive violated SACDC policy. Salters said the email directive was rescinded shortly after Sutherland’s death.

This policy that contradicted the email was SACDC policy 9-14.4 regarding Video Bond Hearing that was dated July 22, 2019, and reviewed October 28, 2020. That policy read:

“The judge will be notified of all inmate refusals to sign the *Consent to Video Conferencing Form*. Inmates refusing to sign the *Consent to Video Conferencing Form* will not continue in the videoconferencing process. Inmates will not be coerced into signing the *Consent to Video Conferencing Form*; signature is strictly voluntary. The Court may request the inmate to make the refusal via video; the Court will reschedule the inmate’s court appearance. The Bond Hearing Detention Deputy will follow-up with the inmate regarding participation in Bond Hearing at each Bond Court Session. If the inmate refuses again, the Judge shall be notified of the refusal. If the

Judge orders that the inmate be brought in front of him/her, the inmate shall be escorted to Bond Court by the Special Operations Group (SOG).”

Magistrate Mel Coleman was the judge presiding over bond hearings on January 5, 2021. He said there was no communication with the SACDC regarding Sutherland and he did not give an order for Sutherland to attend. In fact, he had never ordered an inmate be brought to Bond Court. Magistrate Amanda Haselden, another Bond Court judge, said she too had never required an inmate to attend their bond hearing and added that they had the legal right to refuse.

The policy and Magistrate Coleman’s statements show that there was no legitimate mandate in effect to force Sutherland’s physical appearance in court. In other words, the fundamental premise for requiring Sutherland’s cell extraction was based on false assumptions, making all the ensuing use of force unnecessary. Both Captain Salters and Captain Greathouse should have been familiar with SACDC policy and known that the 2017 email – also the custom and practice of the jail – violated it. As captains, they had an obligation to rectify the conflict long before Sutherland ever came into custody. The evidence did not show if any higher-ranking member of the CCSO was aware of this conflict, but the 2019 policy should have superseded the 2017 email. If there was a reason to revisit the policy and change it, someone in SACDC should have brought it forward rather than simply continuing to violate it.

Generally accepted criminal justice practices, not just jail practices, recognize when someone suffering from mental illness is experiencing a crisis, all reasonable steps should be made to avoid worsening it. The evidence shows Sutherland was in crisis when he entered the behavioral health facility. That crisis continued as he acted out and struck a staff member there. It is widely known that the destabilization of an arrest, admission into a jail environment and then isolation are all contributing factors to further mental health destabilization. Houle and Duvall both properly questioned their orders, recognizing that the impending force on Sutherland was likely pointless and dangerous. Greathouse, as the Command Duty Officer, should have listened, known the policy and tried to have the hearing rescheduled. If there is an underlying event that could have avoided the force used on Sutherland, it was this. One of the fundamental tests when evaluating a use of force is to ask, “Was the force necessary?” It was not, but Houle and Fickett were ordered to extract Sutherland and they reasonably believed the order was lawful.

What is also clear is that the SACDC had used unnecessary force to compel Bond Court appearances since the April 2017 email, likely causing dozens of other unnecessary force events. The SACDC policy was supposedly revised in 2019 and reviewed in 2020, yet the custom and practice continued. The purpose of a policy review is to ensure policy and practice are congruent. Clearly, this did not happen. It was an utter failure of CCSO leadership to allow this practice to exist, especially when it was contradictory to the court's intentions.

### **Cell Extraction**

#### ***Poor Preparation***

While the actual applications of force are disturbing, insufficient staffing and preparation laid the foundation for the chaos that followed. Generally accepted jail practices use four to six deputies to participate in a forcible cell extraction. Fundamentally, this allows for one deputy to enter through the door with a shield, followed by additional deputies to control each of the detainee's extremities. The SOG training had reduced that number to two deputies, and sometimes even one, to complete a cell extraction. While the reasoning for limiting the number of staff is not in evidence, the SACDC clearly bought into the vendor's idea of an elite squad of deputies that would handle all dangerous situations. When asked why staff outside the cell would not come in to help, Fickett said, "They've been instructed to stay out of the way." When pressed further, Fickett said, "Like, we — we, as SOG, are supposed to be able to handle anything. So, unless we are asking for help, they're instructed to keep their distance." That practice is dangerous for both the detainee and staff. As demonstrated in this case, two staff members often cannot control a strong detainee who is actively resisting. With insufficient staff, greater force is often required to subdue and restrain them. At the height of Sutherland's resistance, Fickett and Houle could not control him without resorting to dangerous tactics like repeated Taser deployments and a knee on the back and shoulder.

Had sufficient staff been involved in the extraction, it is doubtful these extreme measures would have been needed. What is especially frustrating in this case is that there were four other deputies outside the cell who could have assisted in safely controlling Sutherland, but because of the bravado culture of the SOG training, those deputies could not assist because they were not SOG

members. In fact, during the fracas, Fennell went inside the cell but it appeared Duvall pulled him out by the arm.

Cell extractions are commonly referred to as *planned use of force events*. The operative word in this phrase is “planned” so that each staff member knows their role, what force is anticipated, who will be responsible for communication, restraints, etc. Fickett described Sutherland’s behavior, saying, “Well, my assessment is, I — I saw where he was in the room. I saw, you know, his size, his stature, and his actions, what he was doing. He was bleating off. He had an object in his hand, and, you know, it seemed like he was extremely agitated, and wasn't — he wasn't listening to Fennel at all.” Houle said, “When we were trying to talk to—when we first initially made contact, he had a breakfast tray in his cell and when we made contact, he had his spoon in his hand like he was holding it, you know—he was holding it, you know, like this, like he wanted to use it as a weapon.” The video evidence shows that Sutherland was repeatedly yelling “hallelujah” as they prepared for the extraction. Fickett said she was never told that Sutherland had a mental illness but also said, “Some people try to play crazy, and but they’re not really.” Houle said he was aware of a mental health concern with Sutherland but could not remember how he knew that. Regardless, Fickett and Houle should have anticipated active, if not assaultive, resistance and created a plan for the extraction that included calling for additional staff, using a cautious escalation of weapons and otherwise anticipating how they could minimize the force necessary to subdue Sutherland and take him to court.

The Use of Force policy required the SOG *supervisor* to:

- a) “Provide direction to staff identifying the force options and security equipment that will be used to accomplish the objective;
- b) Direct application of the force needed to gain and maintain control;
- c) Ensure that another Detention Deputy will operate the video recording equipment to provide complete coverage of the incident.”

The problem in this event is that there was no SOG supervisor. Fickett was no longer in SOG and the designated SOG lieutenant, Duvall, was not SOG trained so according to SACDC custom and practice, he had no role in supervising the extraction.

Fickett later said, “We really don’t need to do a plan.” She explained, “And, you know, being more experienced, I can just feed off of him [Houle], his actions, and I don't really need to — we don't really need to do a plan, you know. We might communicate while we're — while we're working, but beforehand, we know what we're gonna do.” Obviously in this case they did not know what was going to happen, did not have a plan for how to control Sutherland and did not communicate while they were working. Fickett’s interview suggests an arrogance, or ignorance, that contributed to the chaos that ensued during this event. Fickett had many years of SOG experience, and her statement shows that the SACDC had failed to properly train and supervise her. This lack of preparation had been allowed to become their custom and practice.

Sutherland had already been involved in outbursts at the behavioral health facility and the jail. He had demonstrated he would resist. His body language, as shown in the video footage, indicated he was angry and physically tense. The inadequate staffing to properly and safely conduct the extraction fundamentally set the two deputies up for potential, and in this case foreseeable, failure.

More importantly, one of the most critical steps in a planned use of force event like a cell extraction is to avoid the use of force through effective de-escalation techniques. While there was some documentation of de-escalation attempts by Fennell and Duvall before Fickett and Houle arrived, the efforts were not captured on body-worn cameras or documented in reports. The body worn camera video showed Houle made only superficial attempts at de-escalation before he and Fickett resorted to loud commands and SOG intimidation tactics. Shaw later said de-escalation was “integrated” in the SOG training and included instruction in not shouting, using a calming tone, building a conversation with the detainee – and that de-escalation was even more important with mentally ill detainees. None of these techniques existed with Sutherland and the evidence suggests they likely did not happen in other SOG use of force situations.

### *Oleoresin Capsicum (Pepper Spray)*

As Fickett and Houle began to take action, Fickett looked into Sutherland’s cell and commented that he still had the spoon in his hand. A short while later Fickett yelled, “Drop the spoon and come to the door.” Fickett then opened the food port and Houle gave two commands for Sutherland to drop the spoon and come to the door.

Houle then sprayed OC vapor into the cell for about six seconds, creating a fog effect. Sutherland appeared to have a reaction, once lowering his Covid mask and spitting, then wrapping his blanket around his head, a common tactic by detainees to try to minimize the effect of the OC. Fickett and Houle continued to occasionally yell commands and Sutherland said, “What do you want from me?” Houle told him to come to the door and Sutherland asked, “For what?” Houle told him to take the blanket off his head and come to the door. Neither Fickett nor Houle used the opportunities of Sutherland’s questions to engage him in dialogue and try to de-escalate the situation.

Moments later, Sutherland had the blanket draped around the back of his neck, but not his head, and was repeatedly saying “hallelujah” when Houle unlocked the door. Sutherland then reached to his table and picked up his food tray as if he may throw it. Fickett sprayed Sutherland with OC stream, causing him to pull the blanket back up to his face, set the tray back down and move toward his bunk. This second OC deployment was about 3 minutes 51 seconds after the first OC deployment. Unlike the vapor, the OC stream is designed for direct skin contact and causes a burning sensation, watery eyes, a runny nose and mild respiratory distress, among other things. Fickett later said she knew the OC stream made contact with the top of Sutherland’s head and his arm.

Generally accepted jail practices and most manufacturer’s guidelines recommend providing at least five, and more often 10, minutes of time between deployments for the OC to have its desired effect.

The SACDC policy for OC failed to give adequate instruction as to what a reasonable waiting period should be. It read only:

“After an inmate is sprayed, staff should wait for the OC to take effect. A normal person will react to the chemical agent by ceasing resistance, possibly falling to the ground, with the inability to open their eyes, irritated skin, coughing, difficulty breathing, and in some instances, vomiting. These symptoms generally last between five (5) and ten (10) minutes.”

Shaw said there was no policy or training directive on a waiting period after an OC deployment and Fickett, who was an OC instructor, was unaware of any recommendation to provide a waiting

period. She later said that 9/10 times detainee would comply within one minute after the first application of OC. As an OC instructor, she taught that deputies should “give them a chance to have a measurable effect. You don’t just move on to other things right away.” but there was no specific timeframe associated with that instruction.

The 3 minutes 51 seconds waiting period between OC deployments on Sutherland was insufficient and did not meet generally accepted jail practices. However, the SACDC’s OC policy is so vague, saying only “wait for the OC to take effect,” that I cannot assert that it was a violation of agency policy. Fickett said she did not see any effects on Sutherland before she discharged her TASER. The lack of knowledge on the fundamentals of OC use is yet another example of the inadequate training and supervision that the SACDC provided their deputies, and even their instructors.

### ***First TASER Deployment***

In a more standard application of OC, there should be a waiting period of *at least* five minutes after each OC deployment to see if it has an effect. However, Fickett only waited about 51 seconds after the second OC spray before firing her TASER into Sutherland. Fickett and Houle may have reasonably believed the judge who ordered Sutherland’s appearance was waiting for him to appear, causing a false urgency to the situation, but a pause of less than one minute before escalating to the TASER was a serious breach of generally accepted jail training and practice.

Fickett discharged her TASER into Sutherland for about five seconds, causing him to tense and slide to the floor. At the moment Fickett fired the TASER, Sutherland had taken the blanket from around his neck, walked to his bunk and was laying it down (as can be seen in the screenshot at right). It appeared Sutherland *may* have been complying at this time and when asked to explain it, Fickett said they had initially ordered Sutherland to take the blanket off his head and come to the door. However, after they opened the door their commands changed to instructing him



to get down on the floor. At the time she discharged the TASER, she perceived that Sutherland was still noncompliant because he refused to get down on the floor. When asked why she could not have waited longer, Fickett replied, “No. Um, you know, we’re not trained to sit there with the door open, especially with an OC filled room you know, for an extended period of time waiting for somebody to comply. It’s — you know, once we’re at that point, it’s compliance or not. We gave several orders for him to get down and he wasn’t complying with it.”

At a separate time, Fickett was asked why she escalated to the TASER and she replied, “The OC wasn’t having the desired effect. He would not follow commands; he wouldn’t come out of the room; he wouldn’t come up to the door.” When asked if she thought she waited an adequate time, Fickett said, “I think it was more I had an opportunity to use the TASER instead of waiting for the OC to take effect. I wanted to take the opportunity that I had.” Fickett then said, “He didn’t seem like he had any change in behavior from the time I administered it till the time I use the TASER at all. Usually, you know, they start trying to wipe stuff off or, you know, they at least try to come to the sink and, you know, get water on. He was just still pacing around. It didn’t seem like it had changed anything at all.”

The SACDC policy that applied to the TASER authorized its use as follows:

“EMDT devices may be used when a violent or potentially violent person is:

- a. Actively resisting
- b. Aggressively resisting
- c. Displaying aggravated aggressive resistance
- d. Displaying actions indicating an attempt to self-injure or commit suicide
- e. Other emergency situations where the use of an EMDT would be considered objectively reasonable under the circumstances.”

One problem with this policy is the lack of a definition for the above terms. Without definition, there can be varying interpretations as to the different levels of resistance. Some may believe that it was only passive resistance since Sutherland took no physical action against the deputies and was only refusing to comply. It appears the policy did not intend to allow the use of a TASER if this were the case. Others may believe that his grabbing of the spoon and tray, his verbal challenges



and his efforts to defeat the OC constituted active resistance or even aggressive resistance. A second policy issue is that the SACDC used a catch-all phrase, “Other emergency situations where the use of an EMDT would be considered objectively reasonable under the circumstances.” These types of policy phrases only add to the confusion because they effectively say, “Whenever you think it’s necessary.” This policy was poorly promulgated and offered insufficient guidance to the deputies.

Passive resistance, meaning resistance that does not include physical actions against the deputy’s efforts, was not authorized in the SACDC TASER policy at the time of this event. However, the evidence showed the SACDC had, at one time, sanctioned the vendor’s training of using a TASER against passive resistance. Shaw said in 2013 or 2014 the SACDC authorized SOG to use the TASER “in situations with verbal non-compliance.” Previously, the minimum standard had been active resistance. The use of a TASER on someone offering only passive resistance has always violated generally accepted jail practices, yet some jails still allow it. In an undated video of the vendor leading SOG training, with Fickett in the training, he emphasized not to ask or advise, only to give clear commands, and discussed “the intimidation factor”. He also demonstrated techniques involving the use of the TASER including on someone who was only passively resisting and, in a separate example, someone who had only made a verbal threat. CCSO Major Smith [first name unknown] was watching the training but said nothing about the tactics or potential policy violations. At one point the vendor said, “For a bunch of brave guys, we’re cowering behind somebody’s policy or we’re cowering behind words....” The vendor repeatedly referred to the need for force to be “objectively reasonable”, even though his demonstrations were not.

In a separate video of similar training, the vendor again taught the SOG members to use a TASER to overcome passive and verbal resistance. Major Smith was present and watching again. The vendor asked each person, including Smith, if they were comfortable with it. When Smith spoke the audio of the camera was intentionally covered, muffling his response; however, he was smiling and appeared to be approving of it. Using a TASER on passive subjects was no longer acceptable in SACDC policy by 2021, but the evidence did not show if that policy had become the custom and practice.

Fickett did not have a history of excessive TASER use. The frequency of her deployments was reasonable for what might be expected in the SOG role, with only about four prior deployments. There was a previous instance when she used a TASER and the detainee was injured but that act was not directly related to the TASER concerns in this case.

Some of the decisions in this case should be reviewed based on what was in the deputy's mind at the time of the event. Officers can have legitimate perceptions of threat that are not visible on a video recording. In Fickett's mind, this was an urgent situation because they had been ordered by a lieutenant to forcibly take Sutherland to Bond Court. In an interview, Fickett said, "Any bond hearing you wanna get them there as quickly as possible because the judge will be waiting for them." Lastly, in her interviews, Fickett said she was contemplating the worst-case scenarios, like Sutherland attacking them, if she did not deploy the TASER when she did. This "worst case scenario" mentality is not unheard of in law enforcement and sometimes referred to as *catastrophizing*. Law enforcement officers are often taught to be prepared for the worst and can therefore develop thought patterns that overemphasize the preparedness mentality, sometimes causing them to take action sooner than what may be necessary. This general mentality, combined with the SOG emphasis on aggressive tactics and lack of de-escalation training help explain Fickett's state of mind.

This aside, the TASER discharge was effective. Sutherland tensed and slid to the floor, then stayed there.

### ***Verbal Commands***



After the TASER discharge, Fickett and Houle were simultaneously yelling, and sometimes contradicting, each other in their commands. Houle was telling Sutherland to turn on his stomach while Fickett was telling him to slide to the door. When Fickett took charge of the commands, Sutherland began to voluntarily comply and slide across the floor on his buttocks, toward them. While sliding across the floor, Houle again began yelling orders

simultaneous to Fickett, but they were at least similar. While Sutherland was nearing them, he calmly asked to get up but complied when they told him not to. He then asked, “What is the meaning of this?” The deputies did not respond to his question. Sutherland slid toward them until his feet were outside of the threshold of the door. Then the deputies began ordering him to turn onto his stomach, and Sutherland asked, “For what?” They again did not answer his question but kept telling him to turn on his stomach. As they continued to yell at him Sutherland pulled his knees to the side, turned his back partially toward them, put his hands behind his back and said that was as far as he was turning.

A glaring concern up to this point was the continued failure of Fickett or Houle to employ de-escalation techniques. There were many opportunities when they should have engaged Sutherland in calm conversation to lessen the anxiety and hopefully gain his voluntary compliance. Most importantly during their first contact and after the TASER deployment when Sutherland calmly asked to get up and questioned “What is the meaning of this?” The audio/video recording shows he could interact verbally, and the deputies could have engaged him in dialogue rather than just ordering commands. Unfortunately, they did nothing of the sort. They continued to yell commands at him even though jail practices involving mentally ill detainees encourage calm pace, tone and pitch of the voice. The deputies should have used reassurance by calling him by his preferred name, likely Jamal, and encouraging him. Once again though, the evidence shows they were never properly trained in these techniques, nor expected to do them by the SACDC.

Fickett’s training file consisted of 613 pages of documentation. It showed that she completed Interpersonal Communication Courses but there was no evidence of any meaningful training on de-escalation or dealing with the mentally ill. Houle’s training file consisted of 334 pages and also showed no evidence of any meaningful training on de-escalation or dealing with the mentally ill. When Fickett was asked about training on mental illness, Fickett said, “Just, you know, slideshow, classroom stuff, you know, maybe once every couple of years.” And went on to say, “You know, it's — it's you, you might interact with them a little differently. You might have to try different things with a mental health person versus somebody that's not mental health.” She followed up by describing her training in cell extractions, regardless of mental illness, and saying, “No. I mean, that's with — with cell extractions, you know, loud verbal commands are the name of the game, you know, no matter what subject it is.”

Generally accepted jail practices and training emphasize clear and calm verbal techniques with the mentally ill as opposed to “loud verbal commands.” That said, the evidence was also clear that Fickett and Houle were not fully briefed about Sutherland’s mental illness although Fickett said it was “absolutely” an important thing for them to know.

### ***First Handcuffing Attempt***

Sutherland was near the cell door and had placed his hands behind his back but still had his legs in front of him toward the front of the cell. Fickett said, “We wanted him to get on his stomach at that point instead of, you know, staying on his butt, but he wouldn’t turn on his stomach so he, you know, he said, ‘This is as far as I’m turning.’ Just take what you can get pretty much and we can work from there.” When asked why it was important for Sutherland to be on his stomach, Fickett said it was a safer technique because it would have been “harder to get up and turn around and fight us if you are on your stomach versus on your butt or standing up.” Fickett later said, “He ended up stopping, but that’s a closer position to the outside of the room and my partner is just stepping inside the threshold and I still had coverage on him, so you know, we — I took that risk. I told him just to go put him in handcuffs. He had — ‘cause he seemed like he was compliant. He put his hands behind his back and he was just sitting there. He’s like, ‘I’m not turning any further.’ Okay.”

Fickett created a dangerous situation when she directed Houle to move into the cell and handcuff Sutherland. This positioning effectively trapped Houle inside the cell. She explained, “So, I made that decision because we weren’t getting anything else from Sutherland. He wouldn’t come any further, or he wouldn’t get on his stomach. He — he just stopped complying from that point. He still had TASER probes in him, so if he wanted — if he wanted to get up and fight my partner, I could engage the TASER again.”

Later, in an interview, Fickett said, “We try not to be inside the room, but you know, circumstances we ended up in there.” Question: And why wouldn’t you wanna be in there? Answer: “It’s dangerous for everybody involved. It’s dangerous for us to be in that environment. It’s dangerous for us to be in there with the inmate in that — with that environment. It’s more dangerous for the inmate to be with us in that environment, so...”

When asked whether she considered a second TASER discharge to force Sutherland to turn on his stomach, Fickett said she did not deploy the TASER, “Because he started to comply. He started to come out and at that point, you know, I wanted to give him a chance. Um, you know, he was complying. He was coming out of the room.”

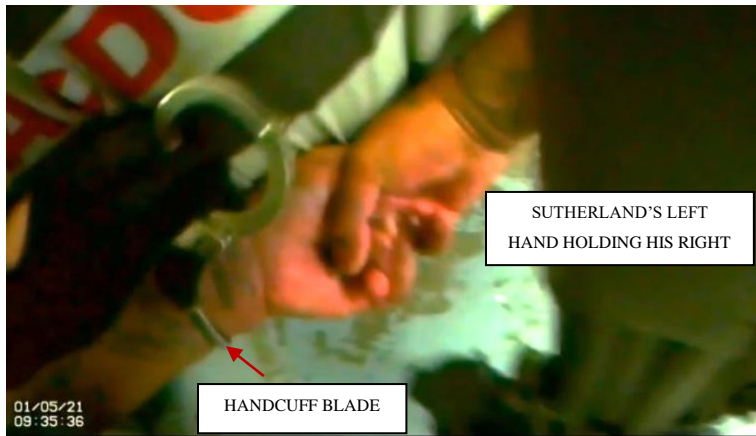
Shaw said SOG deputies were taught to handcuff from a “tactically dominate position” but did not require a detainee to be on their stomach. More importantly, SOG deputies were also taught to remain between the detainee and the cell door during an extraction.

If Sutherland was not coming out farther into the doorway, the deputies should have had him turn his back more to the door to be handcuffed, allowing Houle an escape route should Sutherland become violent. Instead, Houle went into the cell, mostly on the far side of Sutherland, effectively trapping himself.

### *Second TASER Deployment*

Houle said, “I went inside I was able to place one cuff on him. And when I was trying to, attempting to place the second cuff on, he was tightening his arm—pulling away—resisting, ah, for me to be able to secure him. I told him, I directed him to stop resisting so I could put a cuff on. [The video shows Houle said, “loosen up” twice.] He continued, so I placed him on his stomach so I could easier—more easily place cuffs on him—secure him. And when I took him down, ah, to place him on his stomach, Fickett administered the second TASER cycle.”

Houle began handcuffing Sutherland before he had physical control of Sutherland. Houle placed one handcuff on Sutherland’s left wrist but then struggled to control his right arm. During this time, Houle had his shotgun slung across the front of his body and dangling in front of him. Although it is unheard of in other jails to take a loose weapon into a cell when making contact with a detainee, the more significant matter is that it appeared the shotgun may have partially interfered with Houle’s vision and grasp during the handcuffing as it swung back and forth. The evidence on this was inconclusive though.



Another consideration not addressed in the evidence but clearly visible in the screenshot to the left is the high placement of the handcuff on Sutherland's left wrist. The screenshot was taken toward the end of the struggle before Sutherland was rolled onto his stomach and the

second TASER charge deployed. It appears probable that Houle placed the handcuff too high and too tight on Sutherland's left wrist for the other handcuff to reach his right wrist. It is not uncommon for people with large or muscular physiques to have difficulty bringing their wrists together behind their back and if the handcuff was placed too high, it would have made it even more challenging to reach the other wrist. The most common way of dealing with this situation is to attach two pair of handcuffs together, allowing more space between the wrists. This could have been accomplished if more staff were involved in the handcuffing, but since Houle was alone in the cell, it would have been difficult for him to get a second pair of handcuffs while still attempting to control Sutherland.

The evidence did not explore the possibility that the handcuffing of Sutherland was difficult because of limited dexterity and poor handcuff placement. If Sutherland was truly resisting, as Houle believed, it was reasonable that Houle roll him to a prone position. As he did though, he should have been verbalizing what has happening so Fickett would know. "Loosen up" is not a proper instruction and did not help Fickett know that the rollover was Houle's intention. Contemporary training instructs deputies to say "stop resisting." Fickett misperceived what was happening as resistance and discharged the TASER a second time. In her later interview Fickett said, "I don't understand why Houle would wanna roll him over. I just told him to put him in handcuffs." And she said, "Because that would push him further into the room, into that OC-filled room, and that's definitely not where we wanna end up at all." Fickett then said, "All I'm hearing is, "Loosen up. Loosen up." And he's not letting him put him in handcuffs and then he turns and you know, we all go into the room."

A moment prior to Sutherland being rolled onto his stomach, Sutherland seemed to be starting a sentence by calmly saying, “Officer,…” but then a second TASER deployment cut off anything more that he was going to say.

### *The Melee*

When Sutherland was rolled onto his stomach and the TASER was deployed the second time, he lay prone for the remainder of the five second TASER discharge. But when it ended, the situation went out of control. Sutherland became frantic and grabbed Houle’s legs. Houle was backed against the wall and bunk, with no immediate ability to retreat. Houle would later describe it



saying, “I basically tried to get ahold of the cuff and waited for that cycle to be done so I could cuff him real quick. Once that was done, he tried to get up and rush, and he grabbed my legs (as shown in the screenshot). At one point, he had both of his arms around—or his arms around both of my legs. And I was—like I said, I was inside the cell, so I had no way to get out except to go over him and through Fickett.”

Houle described the events that followed. “So, once that second one stopped and he tried to get up, and he grabbed my legs, so we tried to keep him down on the ground. I’m not sure how many times Fickett tased him, but when he rolled over and began fighting us, I thought that her TASER could’ve—the wires could’ve broke because they’re very easy—if you just take them and give a little bit of pressure, they will break. So, I wasn’t sure if they were still connected, so I drew my TASER and give him a directive, fired it, and got him in the upper back, and then that took effect. And once that first one—that first cycle was done, he kept fighting and then—and so, once he started getting a little bit of leverage and was getting up, I cycled it again, and I don’t know if he had wires connected to him or my leg, but I got jolted with it, so I got, I don’t know, a second or two of it. And I don’t remember if I did two or three cycles, but we were finally able to—basically he just went on his—on his—like his chest and he put his arms like this, like just laying on them basically. So, I—Fickett got over his hips to

try to get an arm behind him.” In other interviews Houle reiterated that he believed Fickett’s TASER was not making an effective connection. This poor connection was later confirmed by the Axon/TASER analysis.

The audio/video recording shows Sutherland in highly active resistance and after he initially grabbed Houle’s legs, it is clear that he was raising up, climbing higher on Houle’s body. This mostly occurred right after Houle’s first TASER deployment.



*The screenshots show Sutherland’s head as he rose up toward Houle’s upper legs/waist*

Fickett said, “And then ah, you know, we, we were trying to get him secured on the floor—but he kept trying roll, kept trying to get up, kicking, you know. Just a, just a fight on the floor.” “During the fight, both of--both he and I had TASERS out. I know, I cycled at least one more time—just to try to get him under control. I know Sergeant [Fennell] was behind me; I think he put leg irons on. It was just a...tussle to get both arms back behind him and get him in handcuffs.” “So my concern was, we are in an altercation inside an OC filled room, you know, which is difficult in itself. And, we’re also — it’s Houle and I. Houle’s not the biggest guy in the world. I’m definitely not, you know, large at all. And we’re fighting, you know, somebody that’s a lot larger than us, and seems very, very agitated and very motivated to — to get — get after us, so that’s — that’s my concern.” When asked whether she felt the lockup effect of the TASER was occurring, she said, “No.”

- **Q:** Then you deployed — or re-energized it more throughout the fight? **Fickett:** “I don’t know.” “Yeah, I don’t know. I know I did at least once, but I don’t know of any more.”
- **Q:** Do you even remember how many times you pulled the trigger on your TASER? **Fickett:** “No.”



In describing the events, Fickett said she and Houle were just trying to keep Sutherland down. She said, “He was trying to turn around on us, trying to get up, trying to spin, trying to push himself off the ground.” And when asked how he was trying to get off the ground, she said, “Just by turning around kicking his feet so he can spin. You know, putting his hands underneath him so he would push off.”

Fickett said, “And an open handcuff on his arm can be used as a weapon. If he swings that around and hooks one of us or you know, hits us with the metal, um, you know, we’re trained not to let go of the handcuffs at all if we can help it, ‘cause it’s a weapon.” Houle lost control of the loose handcuff on Sutherland’s left wrist when Fickett fired the second TASER deployment, but he then regained control of it and held it, even as he drew his own TASER and discharged it. However, whether from his TASER, Fickett’s, or something else, he again let go of the handcuff. The struggle continued and it was not until they were getting control of Sutherland that his left wrist came into view from underneath the right side of his body. Fickett reached across and grabbed it, but now there was nothing she could do to keep Sutherland controlled and move his left arm out from under him to bring the handcuff behind his back. The deputies handcuffed Sutherland’s right wrist with a different set of handcuffs and shortly afterward got his left arm out from under his body. At this point there was a set of handcuffs on each wrist.

Generally accepted law enforcement training emphasizes that a handcuff that is only attached to one uncontrolled wrist can be a dangerous weapon if the person begins swinging it. This was clearly a dangerous situation for Fickett, Houle and Sutherland too.

In yet another example of a fundamental flaw in the SOG concept, as soon as Houle chose to use his TASER, the deputies were not physically capable of safely handcuffing Sutherland. Each deputy had one hand occupied with their TASER and at least one of their other hands occupied holding the loose handcuff. That left only one free hand between them, making it impractical for them to control his loose arm and get the handcuff on it. Eventually, Houle had to lay his TASER down on the floor to complete the handcuffing but doing so was also unsafe.

### ***Total TASER Deployments***

Axon, the company that manufactures the TASER, provided an analysis based on the data from Fickett's and Houle's TASERs. The TASER used by Fickett had seven trigger activations for a cumulative total of 35 seconds. It lost connection for 4.6 of those seconds, had a poor connection for 28.4 seconds and had a good connection for 2 seconds. The TASER used by Houle had three trigger activations, all with good connections, for a cumulative total of 15 seconds. In other words, there were ten activations, with varying degrees of connectivity, for cumulative total of 45.4 seconds. 17 of those seconds had good connectivity. Also, some of Fickett and Houle's discharges were concurrent. In interviews, Fickett consistently and repeatedly said she thought she activated her TASER about three times, maybe four.

The TASER literature used during the TASER certification course that both Fickett and Houle attended read:

*In some individuals, the risk of death or serious injury may increase with cumulative CEW [conducted energy weapon] exposure. Repeated, prolonged, or continuous CEW applications may contribute to cumulative exhaustion, stress, cardiac, physiologic, metabolic, respiratory, and associated medical risks which could increase the risk of death or serious injury. Minimize repeated, continuous, or simultaneous exposures.*

*CEW use causes physiologic and/or metabolic effects that may increase the risk of death or serious injury. These effects include changes in blood chemistry, blood pressure, respiration, heart rate and rhythm, and adrenaline and stress hormones, among others. In human studies of electrical discharge from a single CEW of up to 15 seconds, the effects on acid/base balance, creatine kinase, electrolytes, stress hormones, and vital signs were comparable to or less than changes expected from physical exertion similar to struggling, resistance, fighting, fleeing, or from the application of some other force tools or techniques. Some individuals may be particularly susceptible to the effects of CEW use.*

*Most human CEW lab testing has not exceeded 15 seconds of CEW application, and none has exceeded 45 seconds. Use the shortest duration of CEW exposure objectively reasonable to accomplish lawful objectives, and reassess the subject's behavior, reaction, and resistance before*

*initiating or continuing the exposure. If a CEW deployment is ineffective in incapacitating a subject or achieving compliance, consider alternative control measures in conjunction with or separate from the CEW.*

*Do not use multiple CEWs or multiple completed circuits at the same time without justification. Multiple CEWs or multiple completed circuits at the same time could have cumulative effects and result in increased risks.*

Law enforcement professionals have interpreted this to mean there should be a general limit of TASER deployments to three cycles for a cumulative total of 15 seconds. As with most weapons, the greater the resistance and potential for injury to the deputies, the more acceptable additional uses become.

In their 2011 publication *Electronic Control Weapon Guidelines*, the Police Executive Research Forum in Washington DC wrote, “Although causation factors are not clear, the most common factors that appear to be associated with fatal and other serious outcomes include 1) repeated and multiple applications, 2) cycling time that exceeds 15 seconds in duration, whether the time is consecutive or cumulative, and 3) simultaneous applications by more than one ECW. Officers must be trained to understand that repeated applications and continuous cycling of ECWs may increase the risk of death or serious injury and should be avoided.”

The training records showed that on January 30, 2019, and again on February 19, 2021 (after this event), both Fickett and Houle completed TASER certification tests. One True-False question read, “As with any use of force, the longer the CEW exposure the greater the risk of potential cumulative physiologic, metabolic and other effects.” Both accurately marked “True” for the tests in both years.

In her interview, Fickett said she had seen the 15 second caution previously, but added, “You know, we've always been trained you use your TASER to gain control and if the subject is not under control, and you can justify using the TASER, you can.” She went on to add, “So, like — like I said, I'm only — I only intentionally pulled the trigger for those three times. The struggle in the room, I wasn't in, you know, paying attention. I wasn't intentionally pulling the trigger on that TASER. I was just trying to keep him on the floor. You know, I'm trying to fight this man, and

keep him secured on this ground in this OC-filled room. You know, I wasn't consciously pulling the trigger over and over and over again.” At another time Fickett restated that there was no training as to the maximum number of times that someone can discharge a TASER but “It was recommended that you limit as — as much as you can, but if you needed to use the TASER to control the threat, then there was no set number that you needed to stop at.”

As stated, an important consideration with the application of the law, policy, training and generally accepted jail practices is the state of mind, perceptions, and intent of the deputies. Throughout her interviews, including the last one in June 2021, Fickett consistently believed that she had discharged her TASER at least three times but had no recollection of it being seven. Additionally, Fickett was unaware that Houle was deploying his TASER. This phenomenon, commonly referred to as “tunnel vision” is not unusual in highly tense situations.

When Fickett was again asked whether she recalled anything particular about warnings, best practices or maximum/minimum exposures to the TASER, she said, “No.” Houle said he had been taught not to do more than three or four cycles.

Two portions of the SACDC policy related to the TASER read:

- The EMDT is programmed to give one five second burst. The duration of the burst may be shortened by depressing the safety lever at the Detention Deputy’s discretion. Additional bursts may be administered by pulling the trigger if the targeted subject is not controlled by the initial burst.
- Upon firing the device, the Detention Deputy shall energize the subject the fewest times and no longer than necessary to accomplish the legitimate operational objective.

The SACDC policy did not restrict deputies as to the number of times a TASER could or should be discharged. The wording is vague and failed to properly direct deputies as to the precautions that should be taken about the number of discharges and/or the cumulative discharge time and to avoid simultaneous discharges. The SACDC has since modified their policy to restrict more than three discharges.

The vendor was not a TASER instructor but taught the tactical application of the TASER. He said he followed the guidelines from TASER and taught the SOG members to limit the use of the

TASER to two or three discharges. The vendor said there was no instruction about avoiding simultaneous TASER discharges.

A typical TASER discharge is five seconds, but a deputy can shorten that by manually interrupting it. In another example of the poor training that Fickett received, she was asked about reducing the discharge time and said, “So, it's the same for everybody. If you, you know, tase this person for three seconds and this person for five seconds, then they can come back and say, well, you're giving preferential treatment to this one, not that one. So, it was our practice to do the full five seconds for everybody.” So, as a sergeant and force instructor in the SACDC, Fickett somehow came to believe that lessening an application of force on a person may be discriminatory. It is unreasonable to continue a TASER discharge if the deputy knows it is no longer necessary. This practice seemingly reflected her training.

A final note on the use of a TASER that is worth mentioning is whether the deputies could have handcuffed Sutherland while he was incapacitated by the TASER discharge (the roughly five seconds). The goal of a TASER discharge using probes is referred to as neuromuscular incapacitation (NMI). This refers to the involuntary effect of tensing the person's muscles, preventing them from making intentional movements to strike, run or otherwise use their extremities. If a deputy engages the person while the TASER is discharging and NMI is occurring, there is a strong likelihood the deputy will become part of the electrical current flow and suffer the effects of the discharge. Therefore, handcuffing or control techniques are rarely used while the TASER discharge is occurring.

During Fennell's interview with the OPS he said that it seemed like Fickett and Houle were doing everything they could to control Sutherland. Fennell said Sutherland was extremely strong and he could tell that Sutherland had the “upper hand”, so he stepped in to help Fickett and Houle by putting the leg shackles on Sutherland.

### ***Second Handcuffing Attempt***

As Sutherland was being controlled, he now had one set of handcuffs on each wrist. Houle was going to connect the two handcuffs together, but Fickett directed that he use only one pair. When asked why, Fickett said, “Because if you put two handcuffs on somebody, they have a lot of

freedom of movement and they have a lot more chance to fight if they have more freedom to go, so I made the decision to put just one handcuff on instead of two.” As with the initial effort to handcuff Sutherland, it is difficult to determine whether one or two sets of handcuffs was the right decision. Based only on the audio/video recording it appears Sutherland would have been adequately secured with two pair of handcuffs linked together.



The decision to use only one pair caused the deputies to take the additional time to remove the second pair. When asked if she had ever heard anything about people being in a prone position for too long, Fickett said, “I mean, yeah, but it didn’t cross my mind at this point.” The video evidence shows Houle’s knee across Sutherland’s back during this time. The video is incomplete and Fickett’s video (of Houle) was very poor quality. However, it appeared Houle had his knee/leg somewhere

on Sutherland’s upper back/shoulder for about 1 minute 50 seconds, with 1 minute 15 seconds of that time mostly on Sutherland’s center back, as shown in the screen capture. When asked whether Sutherland was doing anything to cause the deputies to stay on top of him, Fickett replied, “We were just making sure if he wanted to turn over and start resisting again that, we were in a good position, in case that happened.” During this time, Sutherland said “I can’t breathe” but Fickett said she did not hear him say it. She said if she had heard that, she would have checked his position and whether they were putting too much pressure on his body, but it would not have changed the tactics that she had been trained on.

Shaw said the SOG training was that one knee could go across a detainee’s shoulder blade area to control them. Generally accepted jail practices do not acknowledge this as a sufficient precaution against compressional asphyxia.

Once Sutherland was restrained and still on his stomach, the deputies put what is commonly referred to as a “spit hood” over his head. When asked why, Fickett said, “Um, because we had to

fight him so much and it's a precaution thing for us so they can't spit on us or bite us and that's a — that's a normal procedure thing for us if, you know, we have a combative person that we've had to use force on, we put a spit mask on them as a precaution." The evidence did not contain a written policy on using a spit hood but Fickett seemed confident in her statement. Also, Houle said the Covid concerns were a consideration. If it was true that they always put a spit hood on someone after they used force, it was yet another misguided and unnecessary custom and practice by the SACDC. Spit hoods are an important tool to prevent biological contamination if a person is intentionally spitting on others. However, they have also been associated with breathing restrictions and generally accepted correctional practices do not support the SACDC's custom and practice of placing a spit hood on any person that they have used force on. It is unnecessary.

Fickett was asked about positional asphyxia or compression awareness and training and said only "they touch on it". She said it was not on her mind with Sutherland because Houle was across his shoulder blade and "we don't have our whole body weight on top of him and, you know, he's not going to be in that position for very long." This statement is concerning and indicates another area of inadequate training by the SACDC. Weight in the inner shoulder blade area can restrict breathing, it does not require full body weight to restrict breathing and the person should be moved off their stomach as soon as practical. Fickett said the Academy instruction taught, "...us not to leave somebody in the prone position for an extended period of time and um, not to put the — your knee on their head or their neck, or you know, it's across the shoulder blade." As to what an "extended period of time" meant, Fickett said, "Um, anything longer than what's necessary. If we just put him in handcuffs in a prone position and walk away, you know, that would be an extended period of time."

Fickett and Houle pulled Sutherland from the cell and medical staff who were present removed the TASER probes. They placed him into the emergency restraint chair and began to strap him in, but then realized he was unresponsive. Sutherland was on his stomach for about five minutes from the time the deputies knelt on him to the time he was lifted into the restraint chair. During this time though, he moved and verbalized inaudible sounds. The medical staff took over Sutherland's care when he became unresponsive. While not relevant to my opinion, it is noteworthy that medical staff took an inordinate amount of time to begin providing resuscitation efforts on Sutherland.

The evidence again showed the policy, training and supervision of the deputies regarding asphyxia concerns was severely lacking. There are times when body weight is necessary to control a violent person, but that weight should be removed as soon as is practical. Fickett and Houle failed to do that and perceived their actions were acceptable.

### ***Investigation and Personnel Action***

After the event, Fickett and Houle were placed on administrative leave for a short time and when they returned to duty they were sent to TASER and OC training. Fickett returned to an administrative position, but the evidence did not show what happened with Houle, other than he had to attend the TASER and OC training as well.

The OPS conducted an inquiry and reviewed the SACDC policy. They wrote, “While applying the video bond hearing policy to Inmate Sutherland’s incident, it is clear to see procedures were violated. However, during this investigation, the Office of Professional Standards exposed a custom and practice related to bond hearing refusals. Almost every employee interviewed stated that it was common knowledge an inmate refusing bond hearing must do so in front of a judge.” The report went on to explain that this custom and practice was in violation of the written SACDC policy and recommended the policy be rewritten.

The OPS investigators also wrote, “Fickett and Deputy Houle gave both applications of OC ample time to take effect in hopes inmate Sutherland would comply.” OPS concluded this element of their analysis with the statement, “The Office of Professional Standards concluded the use of OC by Fickett and Deputy Houle was justified and within the confines of policy.” The fact that the OPS investigators believed Fickett gave “ample time” for the OC to take effect further supports the evidence that the training and supervision in the SACDC was insufficient.

The next section of the report addressed Fickett’s use of the TASER, however the end of that section, likely containing the conclusions, was redacted from the evidence. [Compulsory statements made during an administrative investigation cannot be used in a criminal prosecution.]

Regarding the compressional asphyxia concern of Houle’s knee in Sutherland’s back, the OPS report read, “In Fickett’s body-worn footage, Deputy Houle can be seen placing his left knee on Inmate Sutherland’s back. The knee appears to be on the muscle mass between the shoulder blade



and spine. The audio portion of the video is not clear, but it does sound like Inmate Sutherland says, “I can’t breathe.” Within five seconds of Inmate Sutherland’s statement, Deputy Houle removed his left knee from Inmate Sutherland’s back. Deputy Houle, while struggling to apply handcuffs, then placed his right knee on inmate Sutherland’s back between the shoulder blade and spine. In his second interview, Deputy Houle was very clear he intentionally placed his knee on the muscle mass next to the shoulder blade to avoid contact with inmate Sutherland’s neck and spine. Deputy Houle again confirmed his knee was on inmate Sutherland’s back for about one minute.”

Similar to the concerns with the OPS review of OC use, the OPS report seems to dismiss the compressional asphyxia concerns because Houle’s knee was not on Sutherland’s spine or neck. Compressional asphyxia is known to occur when weight is placed on someone’s back in the very place where Houle had his knee. Deputies should be taught to keep pressure to the side of the torso or on the arms if it is necessary to control someone, but pressure between the shoulder blade and spine is dangerous.

The OPS report claimed to have uncovered “glaring issues” with the TASER policy. There were missing cross-references between the TASER policy and the use of force policy and, as discussed, the TASER policy did not clearly define when it was acceptable and unacceptable to use a TASER. This, combined with the catch-all phrase allowing its use when it “would be considered objectively reasonable under the circumstances” make the value of the TASER policy rather meaningless.

The OPS report concluded with the following:

*On January 5, 2021, Fickett and Deputy Houle were ordered to escort Inmate Sutherland to Bond Court. The lawful order conflicted with policy, but arose from a long-standing custom and practice. Fickett and Deputy Houle followed the Use of Force policy in that they utilized a reasonable amount of force to bring the incident under control. Fickett and Deputy Houle began in their use of force by simply arriving on scene. Their attire and equipment was a warning to Inmate Sutherland the situation had risen to an elevated level. Fickett and Deputy Houle then attempted to resolve the situation through verbal commands. On multiple occasions, both employees ordered Inmate Sutherland to comply with the handcuffing process. Fickett and Deputy Houle then deployed two applications of OC while they continued to plead with Inmate Sutherland*

*to exit the cell. Finally, Fickett and Deputy Houle deployed their assigned tasers. The use of the taser in this situation is within the confines of policy; however, the number of times the taser was deployed must be addressed, The EMDT Policy does not address a maximum number of times a resistive subject can be tased. The EMDT Policy does state, "Upon firing the device, the Detention Deputy shall energize the subject the fewest times and no longer than necessary to accomplish the legitimate operational objective. "*

*Inmate Sutherland continued to resist Fickett and Deputy Houle throughout the entire event; even after he was handcuffed. Fickett and Deputy Houle continued to utilize the taser instead of resorting to hard empty hand tactics/control.*

*Al Cannon Detention Center Policy and Procedure 5-33.5, Use of Force, defines hard empty hand tactics as:*

*Techniques that are impact oriented and include knee strikes, punches, and kicks. Control strikes are used to get a subject under control. Defensive strikes are used by a Detention Deputy to protect them from an attack.*

*The South Carolina Criminal Justice Academy defines hard empty hand control as:*

*Techniques that have the probability of injury. Examples: leg strikes, hand strikes, and neck restraints.*

*According to policy, any application of force by a Detention Deputy must be reviewed by a "reasonableness" standard. Without the guidance of the Use of Force Continuum, Fickett and Deputy Houle had to immediately apply a "reasonable" standard while fighting with Inmate Sutherland and feeling the effects of the OC. Aside from deadly force, Fickett and Deputy Houle only had one other option which would have been hard empty hand tactics. Therefore, the Office of Professional Standards concluded the use of force utilized by Fickett and Deputy Houle during the incident involving Inmate Sutherland was reasonable and within the confines of current policy. Therefore, they are exonerated.*

*The Office of Professional Standards suggest a review of the Use of Force Policy. This policy should identify and describe the different levels of resistance. The Use of Force Policy should also contain language describing the appropriate response to each level of resistance.*

*The Office of Professional Standards also suggest a review of the EMDT Policy. This policy should identify and describe the different levels of resistance. The EMDT Policy should also contain language describing the level of resistance in which a taser can be utilized. Additionally, language should be added to policy giving employees direction as to the number of times a laser can/should be utilized in a single event.*

On May 16, 2021, Fickett and Houle were called to meet the Sheriff whereupon they were each given termination letters. In the letters, the Sheriff acknowledged that Lieutenant Duvall ordered Fickett and Houle to use force to complete the cell extraction but then cited two policies that required force to be reasonable and that the deputies must act objectively. The Sheriff went on to write, “Again, while you acted within the scope of your training and the practices and policy in place at the time of this extraction, there was an opportunity to disengage contact and reverse course. Policy and procedure aside, any personnel ordered into using force in a situation like this have an obligation to use sound judgment and make independent assessment on the decision to continue to use force.” She did not explain when she thought they should have done something different. She then cited a third policy quoting, “[W]hen determining when to apply any level of force and evaluating whether a detention deputy has used reasonable force, a number of factors should be taken into consideration.” The Sheriff then went on to write, “There were numerous factors that should have been taken into consideration such as the fact that Sutherland was brought from Palmetto Behavioral Health Center and suffered from mental illness or the fact that it appeared that Sutherland did not understand the commands given to him at that time.” Fickett and Houle were unaware of Sutherland’s mental health history. In the letter, the Sheriff also cited a policy that read, “Employees will conduct themselves at all times, both on and off duty, in such a manner to reflect most favorably on the Charleston County Sheriff’s Office and Detention Center. Conduct unbecoming of an employee shall include that which brings the Detention Center into disrepute or reflects discredit upon the employee as a member of the Detention Center or that which impairs the operation or efficiency of the Detention Center.” The letter then documented that Fickett and Houle were being terminated.

Fickett and Houle were escorted to gather their belongings and then taken out of the facility. In her interview, Fickett explained, “Get all our stuff, get walked out the building. A couple of hours later, they were like wait, ‘Don’t release the termination letter right now. We wanna do some other things.’ or give them more time to investigate because the investigations weren’t anywhere close to being done. So they were like we can get you, ‘You guys can go on FMLA (Family Medical Leave Act) and—’ Fickett then said “they” suggested Fickett and Houle go to a doctor and be put on FMLA time. They completed that on May 17 but the media reported later that day that the Sheriff’s office had terminated their employment.

A second termination letter, dated May 17<sup>th</sup>, read in part, “Although our findings and conclusions are not yet final as the investigation is ongoing, it has become evident that your continued employment at the jail at this time has resulted in extreme disruption of operations which has to [sic] potential to jeopardize other residents, personnel and citizens.” The letter went on to say that the Sheriff had decided she must terminate their employment and if “compelling evidence come [sic] to light that would definitely exonerate you of any wrongdoing related to the incident”, she would consider reinstatement. Fickett said she received the letter about May 20<sup>th</sup>.

## Conclusions

The SACDC policy was insufficient to guide SOG practices. Generally accepted correctional practices balance the threat of potential resistance or violence by the detainee with a preparation of the potential force necessary to meet the jail's objective, in this case an appearance in Bond Court. For example, less lethal weapons are often prohibited when a detainee is only offering passive resistance. Conversely, de-escalation techniques are not required when a detainee is violently attacking another detainee. The SACDC use of force policy uses the general terms of "reasonableness" and "least amount of force reasonably necessary" but fails to provide sufficient direction in areas like when to use, or not use, empty hand control techniques, OC or a TASER. The TASER policy was insufficient on directing when it could be used, how many times and whether it could be used simultaneous to another TASER.

The SACDC had no policies or procedures on cell extractions. Generally accepted jail practices do not specifically require a cell extraction policy, but they do require a combination of policies and procedures that guide staffing, tactics, use of force and risk avoidance. The SACDC failed to provide adequate policy in all of these areas.

The SACDC also had no meaningful policies on the selection, training, operation or tactics of the SOG members. The vendor had broad authority to do as he wanted and the evidence shows the SACDC leadership turned a blind eye to concerns they should have addressed.

Training and supervision are the greatest influences on deputy's behavior and for all topics related to the use of force in this event, the SACDC's training was seriously insufficient. Even worse, the culture of the SACDC leadership was to look the other way when policy violations occurred and to sanction training that preferred the use of force over avoidance and de-escalation techniques.

There are important investigations that should occur after an in-custody death. The first is a criminal inquiry. These are most often done by another law enforcement agency, in this case, the SLED. As with most investigations by an associated agency, they often lack the scrutiny that a similar case would receive if it did not involve another law enforcement officer. The SLED investigation did not establish intent or state of mind for Fickett or Houle – important elements in determining whether there were criminal acts. It is fortunate that Fickett submitted to an interview

in June 2021 to help answer those questions, but as noted, those statements cannot be used against her in criminal proceedings. Nonetheless, they helped paint the full picture of what happened on January 5 and filled in many gaps left by the previous investigations.

Secondly, there should be an internal investigation to determine if any policies were violated, and if there were any policy, training or supervision concerns. The internal OPS report discussed some of the glaring issues like the longstanding disconnect between Bond Court policy and practice. However, the investigation focused only on Fickett and Houle, when the most obvious policy violations were committed by Salters and Greathouse when they furthered the practice of compulsory attendance at Bond Court. Neither were disciplined. The inquiry also failed to address the inadequacies of the SOG training that contributed to this event. Still, the OPS report found that Fickett and Houle acted within policy and noted that they were ordered to complete the cell extraction. In her termination letters, the Sheriff later said she disagreed with OPS findings but did not explain why.

Other inquiries should have been made and were not. Whenever there is an in-custody death, a jail should conduct a morbidity review to determine if there was anything that should have been done differently, mostly by healthcare staff. The evidence did not establish why Fickett and Houle were not told more about Sutherland's mental health issues or why the healthcare staff seemed so reticent to begin resuscitation efforts after the use of force, but those matters are mostly beyond the scope of this report.

### **Chronological Review of Use of Force Concerns**

This analysis must consider the underlying fact that the entire situation did not need to occur, and only did occur because of the ongoing failures of leadership in the SACDC. While Salter and Greathouse own the direct responsibility for creating this situation, the evidence is clear that the compulsory attendance in Bond Court was a long-standing practice, and the policy violation was openly ignored by CCSO command and executive staff. This practice was the most unreasonable part of this whole incident. A thorough internal review should not only have considered the policy violations but also the harm that had been caused to prior detainees. The OPS report was silent on that matter. Nothing in the SACDC documentation took this into account and maybe most glaringly, the Sheriff terminated Fickett and Houle for vague policy violations of conduct and

discrediting the agency, while nothing was done for the direct policy violations by Salters and Greathouse.

The insufficient staffing of the extraction, that followed the misguided SOG training, also lies at the feet of the CCSO administration. There is no objective research or generally accepted jail practice that recommends only two deputies should perform an extraction in a jail of this size. An unanswered question of this review is how and why the CCSO utilized SOG training that is inherently dangerous for both staff and detainees and substituted weapons and commands for communication and de-escalation. An adequately staffed extraction team could have controlled Sutherland without having to resort to the measures Fickett and Houle used. While the tactics, such as Houle entering the cell behind Sutherland, were poor, even two or three deputies being able to control his arms and legs would have likely eliminated the need for the second and subsequent TASER deployments as well as the compressional asphyxia concerns. It is also likely that Sutherland could have been controlled more quickly and the length of time on his stomach could have been lessened. Similar to the false premise of Sutherland having to personally appear in Bond Court, the failures of the SACDC to use staffing and tactics that conform with generally accepted jail practices was causal to the uses of force that followed.

De-escalation, or the lack thereof, is a consideration in use of force reviews. The evidence shows there were de-escalation efforts made prior to Fickett and Houle being summoned. That does not lessen the importance of them trying additional techniques before they engaged in force. They should have first attempted to calmly and clearly speak with Sutherland, understand his mental state and seek his cooperation. The most obvious concerns are the aggressive and confusing commands to Sutherland. They yelled contradictory commands in a volume and tone that was likely to worsen Sutherland's mental state. They missed several opportunities to engage him in dialogue when he calmly and rationally asked questions. In recent years, the most important conversations in law enforcement are about the avoidance of force. The SACDC did not listen.

Maybe most of all, this analysis has to consider one thing – the way Fickett and Houle were trained. The videos of training show the SOG was taught aggression and intimidation but not effective communication and force avoidance. The SACDC bought into the vendor's misguided concepts of tactical training and allowed him to teach unreasonable force that violated SACDC policy. It is

telling that the SACDC sanctioned the hazing of their own employees for what can only be described as the sadistic pleasure of the vendor since there were no legitimate jail objectives accomplished through the agony of SOG candidates. The jail administration should have recognized the fear-instilling tactics of the SOG may be effective with many detainees, but it was inevitable that something would go wrong, most likely with a mentally ill detainee, and someone would be hurt or killed.

The actual use of OC to gain compliance was within generally accepted jail practices. OC use on the mentally ill has been debated, but because of the failures of the SACDC process, Fickett and Houle did not fully know of Sutherland's mental illness. OC can cause negative reactions with some, but with the way the SOG operated, any alternative would have likely been more harmful. The greatest fault in the use of OC force was the failure to provide a longer waiting period, especially after the second OC deployment. Even with the perception that they were operating under a court order and the judge was waiting, 51 seconds is an inadequate amount of time to allow the OC to have full effect. The SACDC had no waiting period established in policy or training – another failure.

Much could be said about the poor tactics used in this situation, but the most significant factor is Fickett directing Houle into the interior of the cell where he was effectively trapped once the violence began. There were options to try safer handcuffing positions, most notably with Sutherland's back turned more toward the door. Fickett took ownership for ordering Houle into the cell and, while a poor tactic, her decision did not rise to the level of violating generally accepted jail practices.

The first TASER deployment was premature as discussed. By generally accepted jail practices Fickett should have waited to see if Sutherland was complying. She did not wait and later said she was seeking an opportunity to use the TASER, believing Sutherland was not going to comply. The videos of her training show that she was, at least at one point, trained to do exactly what she did. She was taught, at least at one time, to use a TASER against lesser levels of resistance than what Sutherland was demonstrating. Some SACDC staff said the policy had been changed to remove passive resistance from the list of authorized TASER deployments. The failure of the policy and the lack of training documents do not show what the SACDC defined as active resistance though,



so it cannot be established that Fickett violated policy or training when she discharged the first TASER shot. Most similarly situated jails would not authorize the use of a TASER under similar circumstances but some do, and I cannot assert that it violated generally accepted practices.

The precipitating event of the major force was the resistance that Houle perceived while trying to handcuff Sutherland. I cannot establish whether Sutherland was actually resisting, whether he had limited dexterity that caused Houle to perceive he was resisting or whether the high handcuff placement on Sutherland's left wrist made it physically difficult to bring the other handcuff loop to Sutherland's right wrist.

Nonetheless, it was Houle's perceived resistance that caused Fickett to discharge her TASER for the second time. Poor communication between Fickett and Houle led to Fickett making the assumption that Sutherland was resisting by rolling over, when in fact, Houle *meant* to roll Sutherland over. While another example of the poor training of the deputies, Fickett's decision was not unreasonable given that Houle did not communicate and tell her his intentions.

The most serious events occurred after the second TASER deployment. When that cycle ended, Sutherland became frantic and his resistance was active and assaultive. With Houle trapped in the cell, Sutherland grabbing his legs and trying to raise up with the loose handcuff on one wrist, the situation was very dangerous for the deputies. Because it was dangerous for them, it became dangerous for Sutherland. What options did the deputies have given the situation at that moment?

- Empty hand control techniques like wrist locks and arm bar holds – It is highly doubtful two deputies could have controlled a strong detainee like Sutherland with these.
- Additional OC – OC is not designed or recommended for use in close contact. It would likely have had only marginal effect on Sutherland, while now effecting the deputies.
- Less lethal munitions – Despite the absurdity of having shotguns slung around their bodies in this situation, they were too close to Sutherland to safely prepare for a less lethal deployment and too close for the recommended range to use the ammunition.
- Higher levels of force, such as a neck restraint or strikes – The evidence did not indicate whether the SACDC authorized neck restraints, but the deputies were not in a position to use one. Hand or foot strikes may have been effective but are generally considered more harmful than a TASER.

- TASER – The number of deployments aside, the use of the TASER was a reasonable option. With the other options being impractical, the TASER could be used in close quarters and was likely to have the most immediate incapacitating effect with a low likelihood of causing harm.

A key question revolves around the frequency of TASER use and the simultaneous applications. Generally accepted jail practices restrict the use of a TASER to three applications for a cumulative fifteen seconds under normal circumstances. The most common exception is when there is an imminent risk of serious bodily injury to the deputies and, as used here, serious bodily injury includes fractures, lacerations and more serious injuries. When Sutherland became assaultive toward Houle, and had a loose handcuff on his wrist, there was a legitimate risk of Houle suffering serious bodily injury. Fickett described the events later when she said, “It means we’ve completely lost control and we’re in the middle of an OC-filled room and fighting. It’s a bad situation. This is what we didn’t want to happen type of thing.” With the lack of additional personnel to control Sutherland and protect Houle from being injured, both deputies were justified in using the TASERs to protect Houle and subdue Sutherland.

It is a challenging fact that Fickett consistently and firmly believed that she did not discharge the TASER more than three or four times. Certainly not seven. However, in the heat of an intense struggle like this it is not uncommon for a misperception like that to occur. It is most frequently seen in officer-involved shootings when the officer greatly misjudges the number of shots they fired. The evidence also showed that Fickett did not have any pattern or practice of excessive TASER use in her roughly eight years on SOG.

While there are generally accepted jail practices for the TASER in standard situations, there are none that specifically guide the frequency and cumulative exposure against a real or perceived risk of serious bodily injury. It is recognized that the more instances and the longer the exposure, the greater the risk. While shocking to watch, nothing can definitively establish that Fickett’s use was unreasonable or violated generally accepted jail practices when her perceptions are considered.

Handcuffing is a use of force and in this matter, it is worth noting that the delay in completing the handcuffing on Sutherland caused additional exposure to compressional and positional asphyxia concerns. Compressional asphyxia refers to the pressure that was placed on Sutherland’s torso by

the weight of the deputies. Positional asphyxia refers to the time he was left on his stomach. It was clear that Houle's knee/leg was on Sutherland's back for a concerning length of time. His statements showed his poor training when he said he was taught that it was acceptable to use pressure, so long as it was not on the spine. Even the OPS report validated this perception. That idea is dangerous because pressure anywhere in the center mass of the back is known to be a risk for asphyxia. This situation was worsened when Sutherland told them he could not breathe. That said, Sutherland was responsive for some time after the pressure was removed, lessening the likelihood that it contributed to his death.

Dr. Kim Collins, the forensic pathologist, wrote, "The combination of the schizophrenia, medications administered, absence of medications, and the deputies' actions killed Sutherland." The "deputies' actions" included Sutherland's positioning, the use of the spit hood and the use of the TASERs. His medication changes, excitement and agitation also contributed to what Dr. Collins believes was a cardiac event.

The custom and practice of the SACDC to always use a spit hood after a use of force is unreasonable. Not only are there physical impacts from it like keeping OC inside the hood, but it is known to have detrimental psychological effects too, especially on the mentally ill. While Covid was a legitimate concern and a Covid mask would have been reasonable, there was no legitimate jail objective accomplished by putting a spit hood over every person who had been the subject of force. Again though, it is not only the use of the spit hood itself but putting it on took additional time that Sutherland was left on his stomach.

### **Totality of the Uses of Force**

The events preceding Sutherland's death are disturbing to say the least. Most of all, his death was preventable because the cell extraction never needed to happen. After that, the seriously flawed policies, training, supervision, custom and practices of the SACDC combined to create a situation that would have been foreseeable had the CCSO leadership been paying attention. This situation was a domino effect of mistakes. One led to another that led to another.

As I understand it, the key decision for a prosecution is whether Fickett and/or Houle had a "reckless disregard for the safety" of Sutherland. In my opinion, they did not. While their tactics,

decisions and actions violate many generally accepted jail training practices, they did not violate the policy, training and supervision in the SACDC. In my opinion, they were not reckless because they were either doing what they were trained to do or, in the absence of training, they were doing what had become the custom and practice in the SACDC. They were put in an untenable position from the beginning. If criminal liability could be attached to an organization rather than an individual, the CCSO should be charged. As we know though, that cannot happen. The SACDC actively chose to allow the rogue training of SOG and failed to intercede when leadership should have. This event turned out tragically, but the responsibility cannot be solely put on Fickett and Houle. When I was the sheriff of my county and I had to decide disciplinary matters, I would often ask myself, "Has this been an ongoing practice and this deputy just happened to get caught?" As evidenced by the Sheriff's inability to specifically reference an act or omission as cause for Fickett and Houle's terminations, it is clear this was not an anomaly, only the death was.

Sutherland's death could have been avoided if he was never taken to jail. It could have been avoided if Fickett and Houle were not ordered to take him to Bond Court. It may have been avoided if the staffing, tactics and force applications would have been different. While the actions of Fickett and Houle appear to have contributed to his death, their reasons for those actions were based on the failures of policy, training and supervision by the SACDC.

As a former sheriff who made mistakes, my greatest hope is that Sheriff Graziano takes this opportunity to welcome informed perspectives, based on research and best practices, and reform the SACDC jail practices to prevent a future death. There are many resources available to help improve practices in mental health, de-escalation, reduction of force, etc. These practices save lives and can prevent a future event like this.

Respectfully Submitted:

*Gary Raney*, President

**G·A·R, Inc.**  
CRIMINAL JUSTICE CONSULTING  
7154 W State Street, Suite 260  
Boise, ID 83714  
(208) 870-8400  
[www.garyraney.com](http://www.garyraney.com)