

## **An Analysis of the Minneapolis Federal Mediation Agreement By Communities United Against Police Brutality**

Please note: For purposes of this analysis, the Federal Mediation Memorandum of Agreement will be referred to as “the agreement” and the Minneapolis Police Department will be referred to as “MPD.”

### **History**

The summer of 2002 was a difficult period for police-community relations in the City of Minneapolis. A series of high-profile police incidents was capped by the wounding of 11-year-old Julius Powell by a stray police bullet during a botched drug raid. Although the youth was not seriously injured, the incident brought North Minneapolis residents to the boiling point and touched off an uprising in the Jordan neighborhood in which some journalists were beaten and media vehicles were torched.

Prior to the Powell shooting, members of the Minneapolis Police Federation attacked city council member Natalie Johnson Lee for remarks she made in connection with a shooting incident that resulted in the deaths of community member Martha Donald and police officer Melissa Schmidt. Johnson Lee was the only African American on the city council at that time and these attacks on her were seen very negatively by large numbers of her constituents and the Black community as a whole. A rally was held to denounce the attacks, followed by a large community meeting in North Minneapolis to discuss police/community issues. At the rally and later at the meeting, it was announced that an ad hoc coalition had come together, met with U.S. Attorney Tom Heffelfinger and contacted U.S. Department of Justice, Community Relations Section mediator Patricia Campbell Glenn to ask for federal intervention. Two days later, the Powell shooting occurred and the coalition requested that Ms. Glenn come to Minneapolis to assess the situation first-hand.

The coalition met with Ms. Glenn and this meeting led to a four-month effort to bring federal mediation to Minneapolis. There was a great deal of resistance on the part of city leadership. Mayor Rybak repeatedly called for private mediation. The task of bringing federal mediation to the city involved extensive neighborhood canvassing and numerous community meetings to 1) educate the community on mediation and why it was needed, 2) motivate the community to call their council members and the mayor to ask for mediation, and 3) gather input on the community's desired demands for mediation. The final result of these efforts was a ten-page document outlining community demands for improved police policies, practices and accountability.

The community's demands for mediation never saw the light of day. Police Chief Robert Olson stonewalled mediation, refusing to attend sessions with the team elected by the community. He was backed by city council members who strived to control the outcome of mediation by controlling community representation.

Sadly, city leadership finally got their way and in May 2003, a hand-picked “community” team sat down with representatives of the city, the MPD and the federation to broker a federal mediation agreement. Patricia Campbell Glenn served as federal mediator.

### **Overview of Federal Mediation Memorandum of Agreement**

Upon review of the agreement, it is easy to see who was at the mediation table and who was not. In multiple references to various communities of color in Minneapolis, the Latino/a community is not mentioned, leading one to believe that no representatives of that community were present. This is further affirmed by review of the signature pages.

It is also clear from reviewing the agreement that people on the community team were either unaware of the extensive list of demands from the community or chose not to include those demands in the final agreement. One of the community’s strongest demands, for example, was to end the much-hated CODEFOR program of codified racial profiling. This demand is not reflected anywhere in the final agreement. Many other issues important to the community are also missing from the agreement.

For the most part, areas of the agreement related to policies and practices of MPD are recitations of existing police policies. However, when considering increased accountability and reform of the MPD, one must look at both policies and practices. Any police organization can have adequate policies “on the book” but if those policies are routinely ignored without consequences, the practices police officers actually engage in become the *de facto* policies of the department. It is this gap between official policy and actual practice that needed to be addressed by the agreement but was not.

There are a number of specific concerns and issues with the agreement. A detailed assessment of the agreement is below.

### **Specific Concerns**

#### **Section 1: Use of Force**

This section is primarily a recitation of existing police policy, including a reference to a Minnesota statute that prohibits police departments from having use of force policies that are more restrictive than state law. This appears to be a cryptic way of telling the community that it can have nothing to say about MPD use of force.

However, there are many aspects of use of force that are not specifically addressed in state law and that are perpetuated by practice rather than actual MPD policy. An example would be the “shoot-to-kill” practice. While there is no shoot-to-kill policy in writing, MPD officers readily acknowledge that if they discharge their firearm, they do so specifically with the intent to kill rather than debilitate. They are taught to aim at areas of the body (chest, abdomen, head)

where a shot will more likely result in death. While beyond a certain distance it is unrealistic to expect a police officer to successfully shoot at a suspect's extremities, in many instances with mentally ill suspects and others MPD officers were in close range during the shooting and could have delivered a disabling shot rather than a deadly shot. Moreover, MPD officers have engaged in incidents in which large numbers of shots were fired, including at unarmed suspects[1] or long after a suspect was debilitated and on the ground[2]. This practice, which virtually ensures the death of the suspect, has caused enormous pain for the community. Unless a suspect is holding a gun in his or her hand and poses an imminent threat, this practice simply cannot be justified.

Section 1.1.2 – Reporting Requirements: This section reiterates MPD policy requiring an officer to file a report for each instance in which force is used. However, it is our experience that this policy is widely ignored. We have observed a number of incidents in which individuals have visible injuries after an encounter with police, yet no such report has been filed. This area of the agreement would have been strengthened by a provision requiring supervisors to “spot check” whether this policy is actually being followed by the officers under their supervision. It would also have been strengthened by requiring all police officers who witness a use of force incident to file a report.

Section 1.4 – Less Lethal Tools: For the most part, this is a good provision however it does not address the need for MPD to routinely stay abreast of studies related to various sublethal weapons they may add to their arsenal. A number of sublethal weapons have turned out to be more harmful than originally stated by the manufacturer. Examples include plastic/rubber-coated projectiles (“rubber bullets”) and bean-bag guns. Both of these weapons have resulted in multiple deaths but their dangerous nature was not discovered until after they had been widely adopted by police departments. Another helpful provision would have been to require MPD to follow manufacturer's recommendations for use of various sublethal weapons. This both protects the public by ensuring that these weapons are used as recommended and shifts liability to the manufacturer should the weapons turn out to be more dangerous than initially portrayed.

Section 1.5.2 – Hobble: This is a restraint method commonly known as “hog tying.” **We are greatly disturbed by the agreement's seeming endorsement of this inherently dangerous restraint method.** The serious dangers associated with this method are acknowledged by the requirement that a hobble-restrained subject be transported by ambulance, yet there is nothing in this section about how long a suspect can remain in the hobble restraint before an ambulance arrives and nothing directing police officers to release the subject from this restraint if they show signs of respiratory distress. From a practical standpoint, the hobble restraint poses problems because an ambulance crew will need to release the restraint if the individual develops respiratory problems and the individual will then no longer be adequately restrained. Moreover, police departments all over the country are banning the use of the hobble restraint due

to its risks (and increased liability exposure) and this agreement should not codify its use.[\[3\]](#)

Handcuffing: There is no discussion in this agreement related to current MPD handcuffing practices (except a brief reference to not using Flex-Cuffs to effect a maximal restraint technique except in mass arrest situations). Yet, handcuff injuries (known medically as handcuff neuropathies) are the most commonly complained about injuries after an encounter with police.[\[4\]](#) In our work, we receive numerous complaints of injuries after cuffs are applied too tightly. In some cases, people said that when they asked that cuffs be loosened, MPD officers actually tightened them more. In addition, people in tight cuffs have remained in these cuffs for excessive periods. A number of individuals report continued problems with their hands months after their encounter with police. The community would have been better served if this agreement had addressed policy and practice issues related to use of handcuffs.

## **Section 2: Police-Community Relations**

This is, by far, the strongest part of the agreement. This section calls for the creation of a Police Community Relations Council (PCRC) with a number of responsibilities related to improving police-community relations. One area of concern is section 2.2.12, which calls for the development of “a protocol for communications and media contacts” by PCRC members on “critical incidents, high profile police misconduct allegations, and other topics identified by the PCRC.” Let’s hope that this does not become a muzzle for community’s ability to criticize the MPD and to demand change.

## **Section 3: Mental Health Issues**

While the provisions in section 3.1 calling for increasing the numbers and diversity of the CIT team are good, there should also be a continued education requirement for all officers to be trained in basics of mental illness intervention (rather than the one-time training called for in Section 9) so that situations do not escalate out of control before a CIT officer can arrive on the scene. History has shown us the importance of having all officers well versed in the basics of handling mentally ill people.

Restraint methods and continuum of force issues for mentally unstable individuals could also have been addressed here. Many police departments use alternate methods of restraint such as leather straps and use a different continuum of force for mentally ill people. Addressing these areas would have had a real impact on the death and injury rate of mentally ill people at the hands of the MPD.

This section changes the way psychological evaluations are provided to police officers. We are pleased that according to section 3.2 these evaluations will be available from a panel of psychologists. In the past, the MPD has contracted

with one psychologist and if the police officer didn't "connect" with that individual, there were no other options available.

### **Section 6: Racially Biased Policing**

This section starts off with a definition of racially biased policing as "the act of making law enforcement decisions solely on the basis of race." This definition is patently wrong. Racially biased policing is not considered case-by-case but is, instead, determined by reviewing overall patterns. This is by necessity, as police officers will always be able to justify a particular stop of an individual based on their behavior. However, if studies show that a particular officer stops only or predominantly people of a certain race, then the pattern of stops is what shows the bias, rather than relying on the unknowable motivations of a police officer in a particular stop.

Despite the known biased policing issue of CODEFOR and its impact on the community, this program is not dealt with in the agreement. Instead, this section calls for "further research and analysis" rather than actual solutions. Similar to actions by the St. Paul police department, the agreement directs MPD to get business cards for every officer. However, MPD officers are only required to give the cards to people who ask for them, putting the onus on the community member to request the card. If the mediating parties were concerned about people being able to identify police officers, they could have addressed the practice of officers obscuring their names and badge numbers with tape. Although this was banned by city ordinance in 2000, this practice remains a problem, especially during demonstrations and other mass arrest situations. In addition, the St. Paul police card contains text advising people of their rights and mechanism for filing complaints. No such text is called for on the MPD business card.

### **Section 7: Accountability of Police Officers—the Complaint and Discipline Process**

This section is but a weak recitation of currently existing MPD policy. The only real change is that certain organizations/institutions will now be able to pass out complaints for Internal Affairs investigations. This appears to be a reward for organizations involved in mediation. It certainly is no reward for community members, who continue to suffer from retaliatory harassment and arrest after complaining to internal affairs. This would have been an important area for the agreement to address.

The agreement also does nothing about the "complaint gap" between the Civilian Review Authority (CRA) and Internal Affairs (IAU). This gap is comprised of complaints that CRA does not wish to address because they involve a high degree of excessive force. These complaints are referred to IAU. At that point, they seem to fall into a black hole. They are virtually never referred for prosecution. Since an extremely small percent of IAU complaints are upheld (with the vast majority of those being from police leadership)[\[5\]](#), it would seem

that there is no effective place for these complaints to be filed. It is a shame that the agreement did not consider this problem.

The agreement directs IAU to provide “timely” information to the complainant on the status of their complaint and directs the IAU to provide an annual report of their activities. However, it does not provide a mechanism for addressing the lack of activities on the part of IAU. The community would be better served if the agreement contained provisions for oversight of the work of IAU, rather than just a reporting requirement. St. Paul currently has a committee of community members who oversee and evaluate investigations by their IAU. Considering the serious nature of complaints filed with IAU and the historical of lack of follow through on these complaints, Minneapolis would benefit greatly from an IAU oversight committee.

This section would have been an appropriate area to address the issue of C.O.P. (crime on police) charges, which are charges in which a police officer is the alleged victim. These charges include disorderly conduct, obstructing legal process, 4<sup>th</sup> and 5<sup>th</sup> degree assault on a police officer, etc. These are most often used as cover charges for police brutality. As such, these charges should raise a red flag for police leadership and officers who levy these charges regularly should come under special scrutiny. Moreover, a review by the shift supervisor should be required before an individual can be formally charged with one of these known cover charges. This was one of the demands on the original list from the community.

### **Section 9: Training**

While plans for additional training of police officers are a positive, one provision of this section is quite disturbing. Section 9.1.3 calls for training in “the proper application and use of the Lateral Vascular Neck Restraint (LVNR) and the significant distinction between the LVNR and a choke hold.” While there are important differences in the two techniques, a LVNR can easily turn into a choke hold in a situation involving a squirming, combative subject. Moreover, even a perfectly applied LVNR itself involves certain risks.

According to AELE Law Enforcement Legal Center, risks and disadvantages in the use of LVNR include:[\[6\]](#)

1. Neck restraints, if applied improperly, have caused death or paralysis.
2. Due to the dynamics of a violent struggle, it is often difficult to correctly apply such methods.
3. Several instances of "unexplained" death have followed purportedly proper application of the technique, unaccompanied by any discoverable physical injuries. This phenomena, known as "custody death syndrome," is not fully understood, and research is still ongoing.
4. Perpetual and time-consuming training is needed to maintain minimum levels of proficiency.

5. During litigation, it is difficult to precisely explain to a jury the physiological effects of neck restraint procedures, due to an inadequate base of undisputed medical evidence. Even within the medical community, there are disagreements regarding the mechanism that causes unconsciousness.
6. It is difficult for an officer to monitor and control the amount of pressure applied during the procedure.
7. Once the restraint has been applied, there is a need to closely monitor the arrestee. This may be impractical when the individual is hooked into a detention facility operated by another agency.

At minimum, several agencies specializing in law enforcement standards recommend that only officers who have received certification in LVNR be allowed to use it. Certification training can be costly and is only available through designated instructors.

#### **Section 14: Performance, Monitoring and Compliance of the Agreement**

Because mediation is voluntary, compliance with the agreement must be monitored closely. However, under Sections 14.5 and 14.7, it would appear that the only remedy for noncompliance is contacting the Department of Justice for additional mediation. In other words, the document has no real legal “teeth” to compel compliance. This is despite the fact that what the MPD is being asked to comply with is weak to start with.

#### **Missing from the Federal Mediation Memorandum of Agreement**

While there are some new provisions for police/community relations and increasing diversity on the force, very little else about the agreement will have any effect on the rates of police brutality, misconduct and abuse of authority by MPD officers.

Areas that the community expressed concern about that are not addressed in the agreement include:

- \*Police withholding of services to certain neighborhoods
- \*Failure of police to take cross complaints
- \*Lack of neutral investigations and documentation of witnesses by police
- \*Intimidation of witnesses to police brutality
- \*Police officer accounting for time and activities
- \*Although the issue was making news during the time mediation sessions occurred, the lack of MPD policy on field strip and body cavity searches
- \*An end to retaliatory charges for First Amendment-protected speech or for requesting police officer names or badge numbers
- \*Independent investigation of deadly force incidents and sublethal shootings (rather than by the Hennepin County Sheriff’s Department)
- \*Ready availability of duty rosters and 911 tapes
- \*Training police officers in appropriate probable causes for traffic stops based on actual behavior rather than on characteristics

These are just a small number of the demands the community sought. See the attached list of community demands gathered by the original ad hoc coalition for more details.

### **Conclusion**

The quality and nature of police services has a very significant impact on the quality of life for people who live, work or visit Minneapolis. Federal mediation represented an opportunity for the community to make a real impact on areas of concern regarding policing services.

Those who worked hard not only to bring federal mediation to Minneapolis but to ascertain the community's desires for that mediation have cause to feel real frustration that their efforts did not result in a better agreement. Perhaps the desires of the community were not raised at the mediation table. Perhaps the negotiators on the city side of the table simply would not let the community's ideas become part of the agreement. Perhaps the community team was simply out-negotiated by the city side. Whatever the reason, the agreement is clearly a disappointing shell of what it could have been. As a result, community members will be forced to seek justice through other means.

---

[1] Abuka Sanders: At least 35 bullets were discharged by a flank of police officers at Sanders as he sat in his car, ostensibly because he had been "driving erratically." At least 16 bullets hit him. He was unarmed.

[2] Abu Kassim Jeilani: Mentally ill man walking with a machete confronted police officers near the corner of Chicago and Franklin Avenues. One police officer opened fire at close range, other officers joined in. Eyewitnesses report that police officers stood over Jeilani and "emptied their weapons into him" long after he was on the ground. He was shot 16 times.

[3] Reay, Donald T., M.D., Fligner, Corinne L., M.D., Stilwell, Allan D., M.D., Arnold, Judy, Positional Asphyxia During Law Enforcement Transport, *The American Journal of Forensic Medicine and Pathology*, Vol. 13, No. 2, 1992, pages 94, full article on pages 90-97.

[4] Numerous references on this issue are available. In particular, see *Liability Constraints on Human Restraints* at [www.laaw.com/finalre2.htm](http://www.laaw.com/finalre2.htm) or at <http://www.bondforfeitures.com/restraints.htm>. See also <http://www.policeone.com/products/duty-gear/restraints/articles/64675/> on the LA Sheriff's office recall of dangerous handcuffs and <http://www.ncemi.org/cse/cse0920.htm> on medical injuries related to handcuffs.

[5] Blue Card Record List from Internal Affairs Unit and individual records of sustained cases.

[6] See AELE Law Enforcement Legal Center Alert Issue #3 section on Neck Restraints at <http://www.aele.org/alert.html>