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KING COUNTY DEPARTMENT OF EXECUTIVE SERVICES
INQUEST PROGRAM

Case No. 517IQ9301

INQUEST INTO THE DEATH OF
CHARLEENA CHAVON LYLES,
Deceased.

FAMILY RESPONSE TO THE CITY’S
AND OFFICERS’ BRIEFS TO
DETERMINE INQUEST SCOPE

I. INTRODUCTION

The City’s and Officers’ proposals are discordant with the inquest rules and inconsistently applied. The Officers’ scope includes: 1) the Officers’ and Ms. Lyles’s actions related to her death; 2) information and events that bear on the Officers’ decision-making; and 3) information and events that bear on Ms. Lyles’s actions. However, the Officers fail to consistently apply their proposal, choosing to only include information that bears on Ms. Lyles’s or the Officers’ actions when it helps advance their narrative. The City restricts the scope even further, arguing that the only relevant time period is contained within 1 hour and 23 minutes (from the time Ms. Lyles calls 911 to the time of her death). The City’s and Officers’ proposals do not allow the inquest to achieve its purpose of providing a “full, fair, and transparent” review of Ms. Lyles’s death and should be rejected. Conducting Inquests in King County, PHL-7-1-2-EO, Appendix 1, § 2.2 (2018).

1 The appropriate scope is that proposed by the Family, drawn from the inquest rules and
2 essentially mirroring the Officers' proposed (but inconsistently applied) scope. In order to
3 provide a "full, fair, and transparent" review of Ms. Lyles's death, the inquest proceeding must
4 consider the "facts and circumstances surrounding the death," including within the scope *Officer*
5 *McNew, Officer Anderson and Ms. Lyles's actions related to the death and any information or*
6 *events that bear on those actions.* PHL-7-1-2-EO, Appendix 1, § 2.2 (2018).

7 II. ARGUMENT

8 The City's and Officers' briefs are based on two incorrect assumptions about the inquest
9 proceeding. First, both briefs primarily focus on the circumstances that were known to the
10 Officers instead of the circumstances of the death. Yet, the City and Officers have already
11 admitted on multiple occasions that an inquest is not a culpability-finding proceeding. Every
12 time the inquest rules discuss the focus of the inquiry, it is not framed around the actions of the
13 officers, but the facts and "circumstances of *the death.*" See PHL-7-1-2-EO, Appendix 1, § 2.2;
14 5.3; 6.1; Appendix 2, § 3.2; 11.1 (2018) (emphasis added); *See also* King County Charter,
15 Section 895. Since both the Officers' and Ms. Lyles's actions were related to her death, the
16 inquest scope must include those actions and the information or events that bear on them.

17 Second, the City and Officers incorrectly assert that the inquest rules strictly limit the
18 scope of the inquiry to an illogical degree, when instead the rules provide for a "full" review.
19 PHL-7-1-2-EO, Appendix 1, § 2.2, 6.2. The City contends that the rules "contemplate a limited
20 inquiry" and the Officers describe the scope of the inquest as "narrow." *City's Brief* at 10;
21 *Officers' Brief* at 1. Beyond conclusory citations to variations of the phrase "cause, manner, and
22 circumstances of the death," the City and Officers provide no authority for their claim that the
23 inquest is designed to be a narrow inquiry.

24 Indeed, the Officers' and City's positions are wholly inconsistent with the intent of the
25 entire inquest process, i.e. to reassure the community, in a transparent manner, that a police

1 shooting of substantial public concern has gone through an objective process of review and
2 without merely rubber stamping by the police or City. It's not good enough to simply focus
3 inside the window of the shooting. That is no different than choosing to focus on a single
4 paragraph of a chapter out of context. None of the following language is gratuitous: the "public
5 has a strong interest in a full and transparent review of the **circumstances surrounding the**
6 **death.**" PHL-7-1-2-EO, Appendix 1, § 6.2 (emphasis added).

7 Further support for a robust inquest process is found in the provisions regarding the
8 inclusion of all potentially relevant testimony: "there is a strong presumption against the
9 exclusion of witnesses until after their testimony, and relevant, non-cumulative witnesses should
10 only be excluded by the administrator in exceptional circumstances." PHL-7-1-2-EO, Appendix
11 2, § 12.4. Viewed in the context of the actual language of the inquest rules, the rules do not
12 contemplate a narrow inquiry, but a full review, with a strong presumption against exclusion.

13 In outlining the inquest scope, Officers and the City fail to offer a definition of how to
14 determine which information constitutes the *facts* of Ms. Lyles's death and which information
15 constitutes the *circumstances*. PHL-7-1-2-EO, Appendix 1, § 2.1, 2.2, 5.3, 6.1. All of the
16 information included within the inquest scope under the Family's definition of the *facts* of Ms.
17 Lyles's death—Officer McNew, Officer Anderson, and Ms. Lyles's actions directly related to
18 the death—is also included within the scope proposed by the Officers and the City.

19 The Officers and City offer different definitions of what can be considered the
20 "circumstances" of Ms. Lyles's death. The Officers adopt a definition similar to the definition
21 proposed by the Family. They include among the circumstances of Ms. Lyles's death,
22 information that bears on Ms. Lyles's actions in allegedly holding a knife shortly before her
23 death. Specifically, the Officers explain that a prior report of Ms. Lyles holding a knife in front
24 of neighboring children "is relevant and admissible as it relates directly to Ms. Lyles' [sic]
25 history of using a knife to threaten others prior to her encounter with Officers Anderson and

1 McNew on June 18, 2017.” *Officers Brief* at 11. By their own logic—that prior events which
2 bear on Ms. Lyles’s actions are within the scope—the Officers admit to the relevance of other
3 information related to Ms. Lyles’s mental health, including those events in the Family’s Brief on
4 pages 13-18.

5 In the following paragraphs, this Brief will consider the specific scope outlined by the
6 Officers and City, using the general structure they adopt: 1) facts and circumstances; 2) training;
7 and 3) policy.

8 **A. The City’s theory of inquest scope is inconsistent with the inquest rules by failing to**
9 **account for the circumstances relevant to Ms. Lyles’s death**

10 Unlike the Family and Officers, the City argues that all information outside of a 1 hour,
11 23 minute window is irrelevant and outside the scope of the inquest, ignoring many of the
12 circumstances that bear on Ms. Lyles’s actions. While the City’s scope definition might appear,
13 on its face, to offer a tidy way to define scope, it is inconsistent with the inquest rules and fails to
14 withstand serious scrutiny. The inquest is not a culpability-finding inquiry solely focused on the
15 Officers’ actions, but instead is focused on the “facts and circumstances surrounding *the death*.”
16 PHL-7-1-2-EO, Appendix 1, § 2.2 (2018) (emphasis added). The facts and circumstances
17 surrounding *the death* involve not just the Officers’ actions and the events and information that
18 bear on those actions but also Ms. Lyles’s actions and the events and information that bear on
19 those actions, even if unknown to the Officers.

20 A ruling that the inquest scope must be limited to those circumstances known to officers
21 would have clearly undesirable consequences. For example, suppose officers killed an individual
22 after he failed to comply with commands to stop reaching into his waistband. However, after the
23 shooting, the officers learn that the individual had a substantial hearing impairment that likely
24 prevented him from hearing their commands. Under the City’s definition of the circumstances of
25 the death, the inquest would avoid all discussion of the individual’s inability to hear commands

1 because the officers were unaware that he suffered a hearing deficit. As a result, the inquest
2 panel would be left to reach the erroneous conclusion that he chose not to follow officers'
3 commands. Clearly, in such a situation, no inquest would proceed by ignoring information that
4 bears on the nature of the individual's hearing deficit and leads the inquest to reach erroneous
5 determinations. Similarly, Ms. Lyles had disabilities that directly bear on her actions related to
6 her death. It would be equally problematic to exclude information from this inquiry that speaks
7 to the nature of her mental illness.

8 The City's scope also incorrectly results in the exclusion of information relevant to
9 potential officer error. For example, consider a situation where an officer responds to a call and
10 neglects to adequately review and take appropriate action regarding Officer Safety Caution
11 information when he has the opportunity to do so. As a result, he puts himself in a deadly force
12 situation that could have otherwise been avoided. Under the City's theory of scope, the inquest
13 would completely ignore how information that officer should have reviewed could have changed
14 his actions and prevented the use of deadly force.

15 **B. The Officers fail to consistently apply their theory of inquest scope**

16 The Officers fail to consistently apply their theory to the facts and circumstances of Ms.
17 Lyles's death and, instead, only choose to apply their theory when it helps advance their
18 narrative. For example, although the Officers claim that a prior report of Ms. Lyles holding a
19 knife in front of neighboring children should be within the inquest scope because it bears on Ms.
20 Lyles's actions, they also claim that information about Ms. Lyles's mental illness, which bears
21 on her actions, is outside the scope of the inquest. A full and fair inquest inquiry does not support
22 this biased approach.

23 Furthermore, the event involving Ms. Lyles holding a knife in front of neighboring
24 children is so intertwined with Ms. Lyles's mental illness and history as a domestic violence
25 victim that it cannot be considered outside of that context. *See Family Brief 15-17.* Ms. Lyles

1 demanded her “12 rolls of toilet paper” from a 10-year-old on the playground and when she later
2 returned holding a knife, she referenced her “dead” ex-boyfriend, despite the fact that no such
3 person existed. Declaration of Corey Guilmette filed with Family Brief (Exhibit 2). That same
4 weekend, Ms. Lyles’s ex-boyfriend refused to leave her apartment, smashed her cell phone,
5 choked her and then punched her in the face. Declaration of Corey Guilmette (Exhibit 19).
6 Additionally, that weekend, Ms. Lyles called 911 alleging that, late at night, children were
7 ringing her doorbell and taunting her while their mother was threatening to harm her. Declaration
8 of Corey Guilmette (Exhibit 20). Although the Officers seek to present the event involving the
9 10-year-old and Ms. Lyles’s demand for 12 rolls of toilet paper as a simple example of Ms.
10 Lyles’s history of threats, separate from her experiences of mental illness (and domestic
11 violence), such a framing betrays the truth of what actually occurred. Ms. Lyles’s demand for 12
12 rolls of toilet paper and statement about her non-existent dead ex-boyfriend was a product of her
13 mental illness and intertwined with her experience as a victim of violence. Just like the events
14 that led to her death, information about this event cannot be understood without also considering
15 Ms. Lyles’s mental illness and its intersection with her experiences as a victim of violence.

16 Furthermore, the Officers’ exclusion of Ms. Lyles’s mental health history from the
17 inquest scope is entirely inconsistent with their claim that training on mental illness is within the
18 scope. *Officers’ Brief* at 6. In the inquest the Officers will claim that they appropriately
19 responded to Ms. Lyles’s mental health crisis, but seek to do so without addressing any
20 circumstances that would explain the nature of that crisis or otherwise put it into context.

21 The Officers also reject considering Ms. Lyles’s mental health by feigning concern that
22 doing so would “needlessly prejudice Ms. Lyles’ [sic] position.” *Officers’ Brief* at 4. The
23 Officers’ claim about prejudice reflects an outdated conception of mental illness as something to
24 receive societal shame. If Ms. Lyles had a physical disability that impacted her actions prior to
25 her death, the Officers could not genuinely claim that such a disability should be excluded as

1 prejudicial. There is no reason that Ms. Lyles’s mental illness cannot be considered in a
2 professional manner, allowing the inquest to address one of the most important circumstances
3 surrounding her death. There will be no prejudice to Ms. Lyles unless the Officers and City
4 attempt to use the fact and circumstances of her mental illness against her in an unfair or
5 derogatory manner. In that event, the Administrator may halt such behavior.

6 **C. The City and Officers fail to apply their own theories of inquest scope to determine**
7 **which training should be included within the inquest**

8 The City and Officers fail to provide a logical basis for determining which trainings fall
9 within the inquest scope. As a result, they omit training topics relevant under their very own
10 theories of inquest scope.¹ For example, the City excludes first aid training, despite including the
11 Officers’ attempts (or lack thereof) to render first aid as part of the scope.

12 The City also excludes training related to engaging with individuals with mental illness.
13 Yet, during the 1 hour, 23 minute timeframe of the City’s proposed scope, Officer Anderson: a)
14 learned of Ms. Lyles’s mental illness from an Officer Safety Caution; b) discovered its nexus
15 with an event days prior in which she allegedly held scissors in the presence of officers; c)
16 adapted his response by calling for a second officer; and d) talked with Officer McNew about
17 where to position himself based on the caution. *Bates No. 563, 638*. Clearly training on mental
18 illness or mental health crisis was relevant to the Officers’ actions even within the City’s overly
19 narrow proposed scope.

20 Similarly, the City and Officers fail to include any training on how to respond to an
21 Officer Safety Caution, even though, as explained in the previous paragraph, such training falls
22 within both of their scope definitions.

23 _____
24 ¹ As of the date of this Response, the City has still not provided any training descriptions or met with the family to
25 discuss training topics, as ordered to do in the pre-inquest conference on September 10, 2019. Since the Family does
not have training descriptions from the City, it cannot be sure its understanding of topics addressed by the training
materials listed in the City’s brief is correct.

1 They also do not include training on team tactics, even though team tactics were relevant
2 to the Officers’ “decision-making,” including during the City’s scope timeframe. *Officers’ Brief*
3 at 7. For example, Officer McNew described himself as a “cover” officer during the call and also
4 instructed Officer Anderson to fire his taser while he provided lethal cover. *Bates No.* 645, 668.

5 Although the City includes less-lethal option training within the inquest scope, the
6 Officers do not, even though less-lethal option training was “relevant to the officers’ decision
7 making” by instructing officers as to what use of force options were appropriate in the situation.
8 *Officers’ Brief* at 7.

9 The only use-of-force tool training specifically addressed in the Officers’ Brief is taser
10 training. The Officers claim that taser training is irrelevant because no taser was present,
11 conveniently ignoring the fact that no taser was present because Officer Anderson chose not to
12 carry his taser—a decision that SPD found to be a violation of policy and resulted in his
13 suspension. *Officers’ Brief* at 6; Declaration of Corey Guilmette (Exhibit 21). Seconds before
14 officers shot Ms. Lyles, believing that Officer Anderson was carrying his taser, Officer McNew
15 yelled “taser,” in a request for Officer Anderson to fire his taser at Ms. Lyles. *Bates No.* 645.
16 Had Officer Anderson carried his taser, as required under department policy, he would have been
17 able to comply with Officer McNew’s directive and Ms. Lyles may very well be alive today.

18 The Officers further claim that taser training is irrelevant since tasers are not to be used in
19 deadly force situations. *Officers’ Brief* at 5-6. Whether a taser was a trained response given the
20 circumstances is a question for the inquest panel to determine, not an issue relevant to scope.
21 Furthermore, the Officers’ claim that a taser is inappropriate when confronted with a deadly
22 weapon is false. The Seattle Police Department (SPD) Taser X2 training, which Officer
23 Anderson received in 2015, states in its Executive Summary, “a TASER can also be an effective
24 force option against subjects who might be possessing potentially deadly weapons such as
25 knives.” *Bates No.* 625-626.

1 While the City includes bias training within its scope, the Officers argue that bias training
2 is irrelevant to this inquest. *Officers' Brief* at 5-7. The Officers fail to actually address the
3 Family's explanation of why bias training is within the inquest scope. They argue that there is no
4 evidence of explicit bias by the Officers. *Id.* at 5. However, the Family never claimed that bias
5 training was relevant because of known explicit bias.

6 The Officers claim that training on what they call "inherent bias" is irrelevant because
7 there is no evidence that "inherent bias" contributed to their actions.² *Id.* at 6. As explained in the
8 Family's previous briefing, implicit bias, by its very nature, cannot be demonstrated outside of
9 controlled experiments. That there is no evidence of implicit bias is a completely meaningless
10 statement—as that is always the case in a police shooting.

11 Ultimately, the Officers reject the inclusion of implicit bias training because it is
12 impossible to prove that the Officers carried implicit bias. *Id.* at 6-7. However, this misses the
13 point. Implicit bias training is not relevant because it aids in understanding whether the Officers
14 were biased. Implicit bias training is relevant because it teaches all officers to engage in actions
15 to counter potential unconscious biases they may have.³ The relevant inquiry is whether the
16 officers took the steps outlined in their implicit bias training. Whether the Officers actually
17 harbored any implicit bias is irrelevant to this inquiry.

18 **D. The Officers fail to include SPD policy that is within the Officers' own scope**
19 **definition**

20 The City, Family, and Officers propose very similar inquest scopes related to SPD policy.
21 However, in conflict with the City and Family's proposed scopes, the Officers do not include
22

23 ² "Inherent bias" is not a commonly used in term in relation to unconscious racial bias. The Family assumes that, in
referring to "inherent bias," the Officers are referring to what is commonly called "implicit bias."

24 ³ Through routine monitoring and other techniques, implicit bias training allows officers to reduce racial bias,
including in how they respond to perceived threats. Mitchell, Renée & James, Lois, *Addressing the Elephant in the*
25 *Room: The Need to Evaluate Implicit Bias Training Effectiveness for Improving Fairness in Police Officer Decision-*
Making, Police Chief Magazine, <https://www.policechiefmagazine.org/addressing-the-elephant-in-the-room/>

1 SPD Manual Title 8.300, which governs use of force tools, despite the fact that it falls within
2 their own scope definition. For example, Title 8.300-Pol-3(7) states that officers, when feasible,
3 shall issue a verbal warning prior to discharging their firearm. Given that the Officers discharged
4 their firearms in shooting Ms. Lyles, policy related to the firing of their weapons is “relevant to
5 the officers’ decision making.” *Officers’ Brief* at 7. Additionally, former SPD Manual Title
6 8.300-POL-3(3), which required officers to carry their issued taser, falls within the Officers’ own
7 proposed scope because Officer Anderson’s failure to carry his taser influenced the use-of-force
8 options he had available and thus was “relevant to the officers’ decision making.” *Id.*

9 **E. The Officers’ response to the Family’s Discovery Demand is duplicative and**
10 **irrelevant to the requested briefing**

11 The Officers’ Response to the Family’s August 2019 Discovery Demand is duplicative
12 and irrelevant to this briefing. To that end, the Family directs the Officers to review the briefing
13 already filed on those issues.

14 **III. CONCLUSION**

15 The inquest serves the public’s “**strong interest in a full and transparent review of the**
16 **circumstances surrounding the death.**” PHL-7-1-2-EO, Appendix 1, § 6.2 (2018) (emphasis
17 added). This purpose would be thwarted if the scope is unduly restricted and unfairly applied in
18 the manner proposed by the City and Officers. The inquest should adopt the Family’s scope
19 definition, which is directly drawn from the inquest rules and consistently applied. The inquest
20 should provide a “full, fair, and transparent” review of Ms. Lyles’s death and consider the “facts
21 and circumstances surrounding the death,” including within the scope *Officer McNew, Officer*
22 *Anderson and Ms. Lyles’s actions related to the death and any information or events that bear*
23 *on those actions.* PHL-7-1-2-EO, Appendix 1, § 2.2 (2018).

1 JOINTLY filed this 11th day of October, 2019.

2
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CERTIFICATE OF SERVICE

The undersigned certifies under the penalty of perjury according to the laws of the United States and the State of Washington that on this date I caused to be served in the manner noted below a copy of this document entitled **FAMILY RESPONSE TO THE CITY'S AND OFFICERS' BRIEFS TO DETERMINE INQUEST SCOPE** on the following individuals:

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DATED this 11th day of October, 2019.

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