

Review of Virginia Beach Sheriff's Office's Policies, Procedures, Training, Tactics, Techniques, Tools, Equipment, and Culture Related to Response to Resistance and Use of Force



Review of Virginia Beach Sheriff's Office's Policies, Procedures, Training, Tactics, Techniques, Tools, Equipment, and Culture Related to Response to Resistance and Use of Force

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Overview

On June 4, 2024, Rolin Hill became unresponsive at the Virginia Beach Correctional Center (VBCC)¹ after a use-of-force (UOF) incident involving restraint by members of the Virginia Beach Sheriff's Office (VBSO).² The medical examiner ruled the death a homicide due to "positional and mechanical asphyxia due to restraint with neck and torso compression."³ Three members of the VBSO have been indicted and, as of this writing, await trial.⁴ Mr. Hill's death is the first known in-custody homicide inside the VBCC in reported history.

In the wake of this tragic loss of life, the VBSO and the City of Virginia Beach issued a Request for Proposals for a review of various aspects of the VBSO's policy and training. The Police Executive Research Forum (PERF) was awarded the contract, and VBSO asked us to perform the following work:

1. Review VBSO policies and procedures related to "response to resistance" (RTR, the VBSO's term for use of force) and UOF.
2. Review training lesson plans.
3. Review previous RTR incidents.
4. Observe processes including intake, classification, and RTR incidents.
5. Observe basic academy and in-service RTR training, including defensive tactics and use of restraint devices.
6. Interview various staff at each rank.

Upon completion of those tasks, VBSO asked PERF to do the following:

1. Determine whether the VBSO UOF and RTR policies and practices align with best practices in the field.
2. Identify areas where VBSO's policies and practices meet or exceed best practices.
3. Make recommendations for needed and suggested improvements.

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1. The use of "VBCC" throughout this report refers to the adult facility.
 2. Taylor Brokesh, "Virginia Beach Deputies' Trial Delayed in Rolin Hill Homicide Case; Defense Seeks More Prep Time," 13NewsNow, last modified July 8, 2025, <https://www.13newsnow.com/article/news/crime/trials-delayed-for-all-3-former-deputies-in-rolin-hill-homicide-case/291-a2db8856-4a31-4b88-acd2-9eed6a21e3b0>.
 3. Christopher Collette, Preston Steger, and Stephanie Johnson, "Virginia Beach Inmate's Death Ruled a Homicide; Five Deputies No Longer Employed with Sheriff's Office," 13NewsNow, last modified October 18, 2024, <https://www.13newsnow.com/article/news/local/mycity/virginia-beach/deputies-no-longer-employed-vbso-virginia-beach-rolin-hill-homicide/291-bba1324b-6144-4a94-b22c-54cf78e7a7de>.
 4. Brokesh, "Virginia Beach Deputies' Trial Delayed" (see note 2). Because the case is pending trial, we did not review the criminal investigative paperwork related to the Rolin Hill incident, nor will we comment on the facts of that case in this report, except tangentially, as necessary and relevant.

Interviews and Observations

During PERF's site visit in July 2025, the team met with the following members of the VBSO:

- The sheriff and members of his executive staff
- Members of the Professional Standards Office of varying ranks
- Floor supervisors
- Floor deputies
- Defensive Tactics training staff
- Members of the contracted medical staff
- Nonsworn (i.e., professional or civilian) intake and administrative staff
- Sworn intake staff
- Sworn intake supervisors

In addition, PERF toured the VBCC facility and observed the intake and classification processes. PERF members also observed members of the VBSO academy engaging in scenario-based training regarding people in mental crisis and in-service training on "positional asphyxia" (the VBSO's term for restraint-related death), as well as in-service defensive tactics training.

Through confidential interviews with staff across various ranks, we found that members of the VBSO take pride in their work and view the Rolin Hill case, which prompted this review, as an isolated and atypical incident. While many at the sheriff's office acknowledged that certain policies and practices could benefit from updating, they shared a consistent belief that their agency strives to deliver services that uphold the dignity and humanity of those in its custody—particularly individuals affected by mental illness, substance use, or both.

Similarly, our review of VBSO's training lesson plans shows well-organized material that supports practical scenarios. The training itself—both at the academy level and during in-service sessions—revealed a high level of engagement among cadets and current staff. The instruction was robust and grounded in realistic, scenario-based exercises that reflect the complexities of modern jail and patrol operations.

In addition to defensive tactics and restraint-related death, training modules included a hands-on exercise involving the use of a safety restraint chair⁵ and a simulation requiring staff to de-escalate a situation involving an individual with a mental illness who was shouting in public. These sessions were carefully designed and challenged participants to engage with difficult subject matter in a controlled, supportive environment.

In this report, PERF presents its findings and recommendations for the VBSO.

In the section that follows, we examine the 2024 RTR data in detail. This examination includes a review of when and where incidents occurred, the characteristics of the individuals involved, and the operational factors that shaped these encounters. Together, these analyses illustrate the patterns and challenges within VBSO's current approach to documenting and managing force.

The report then evaluates the agency's policies, training programs, and reporting systems. This assessment identifies areas where the agency's practices align with contemporary standards, as well as those that would benefit from updating, consolidation, or greater clarity. Particular attention is given to the constraints of the existing manual reporting process and how they affect oversight, data management, and decision-making.

Finally, we offer a series of recommendations informed by the full scope of the review. These recommendations are designed to support improved data integrity and transparency, strengthen accountability mechanisms, and enhance safety.

Taken together, the recommendations in this report outline practical steps VBSO can take to build on its existing strengths and ensure safer, more consistent, and more transparent operations moving forward.

5. The chair looked similar to, but may have been a different brand from, this chair: "Sureguard® Safety Restraint Chair," Safety Restraint Chair, Inc., accessed February 24, 2026, <https://restraintchair.com/sureguard-restraint-chair.php>.

Overview of 2024 Uses of Force

The most substantial and labor-intensive component of PERF's review was a comprehensive analysis of all reported VBSO UOF incidents—which the agency refers to as RTR incidents—from January 1 through December 31, 2024. This analysis involved PERF staff conducting a meticulous review of 457 incidents to extract meaningful data.

This effort, which PERF initiated at VBSO's request to gain a clearer understanding of its RTR use and practices, reflects the agency's commitment to transparency and self-assessment. However, the analysis quickly revealed two critical issues within VBSO's current systems:

1. The agency dedicates considerable time and resources to documenting minor incidents that in many other jurisdictions would not meet the threshold to qualify as an RTR.
2. The need for the type of extensive manual review that PERF undertook highlights the limitations of VBSO's existing data capture systems, which are outdated and do not support comprehensive analysis.

The findings highlight the importance of modernizing internal systems to ensure future analyses are both efficient and impactful. As noted later in this report—and to the agency's credit—VBSO has begun the process of implementing an automated system. That effort is commendable; it must now be prioritized and completed.

Definition of “Response to Resistance” and Reportable Uses of Force

According to **General Order 11-01-00 - Response to Resistance**, the VBSO defines RTR as *An effort to compel compliance by an unwilling subject. Unresisted handcuffing does not comprise the response to resistance.*

Capturing RTRs is an essential responsibility for every agency. However, VBSO's definition is notably broad. Under the current policy, even verbally compelling an initially unwilling individual to enter a cell—without any physical contact—would seem to qualify. This expansive scope has significant implications for reporting and documentation.

General Order 11-01-00 (11) goes on to require that deputies report and document *all* RTR incidents, without qualification.⁶ Deputies therefore spend considerable time documenting events that many other agencies would not record—much less classify—as UOF or RTR incidents. In addition to the burden of deputy time spent complying with these definitions, this broad documentation practice may lead to public misunderstanding. Observers who see only the total number of RTR incidents at the VBSO may not realize that the agency captures a broader range of events than other comparable agencies, potentially skewing their perceptions of deputy conduct.

6. Based on our review, despite the current policy, most verbal compulsion—only RTRs are not documented.

And finally, such a broad definition of reportable RTRs risks obscuring significant incidents within the volume of minor events. PERF therefore recommends that VBSO consider either (a) revising the definition of RTR in its policy, (b) revising the criteria for which RTRs must be reported, or (c) both.

Definition of UOF / RTR

Most other agencies define UOF/RTR more narrowly than the VBSO, limiting it to various levels of physical compulsion. For example, consider the following:

- The Harris County (TX) Sheriff's Office, one of the largest full-service sheriff's offices in the nation, defines force as "The application of **physical techniques or tactics**, chemical agents, or weapons to another person. It is not a use of force when a person allows him or herself to be searched, escorted, handcuffed, or restrained."⁷
- The St. Mary's County (MD) Sheriff's Office, a smaller full-service sheriff's office, defines force using the same language as Harris County (quoted in the previous item).⁸

This definition more closely aligns with what most law enforcement professionals would reasonably consider a UOF/RTR and may serve as a helpful model for refining VBSO policy.

Reportable RTRs

Regarding reportable RTRs, VBSO can obtain guidance from the Seattle (WA) Police Department (SPD), whose policies arose during a federally monitored consent decree and have therefore undergone and withstood federal scrutiny. Pursuant to SPD policy, "*All uses of force are reportable except de minimis force.*"⁹ The policy goes on to define de minimis force, establish a threshold, and provide examples, as shown in table 1 on page 6.

Similarly, the Baltimore (MD) Police Department, which is currently under a federally monitored consent decree, requires all uses of force to be reported and documented. Still, they must first meet the minimum threshold of a level 1 UOF, defined as follows:

"Level 1 Use of Force — Includes:

- Using techniques that cause Temporary Pain or disorientation as a means of gaining compliance, hand control or escort techniques (e.g., elbow grip, wrist grip, or shoulder grip), and pressure point compliance techniques. Force under this category is not reasonably expected to cause injury,

7. "501-De-escalation & Response to Resistance," Harris County Sheriff's Office, last modified December 11, 2024, <https://hcsopolicy.com/policy/501-de-escalation-response-to-resistance/> (emphasis added).

8. "Policy 300: Use of Force," LE Policy Manual (Leonardtown, MD: St. Mary's County Sheriff's Office, 2025), <https://www.firstsheriff.com/policies/3/0/>.

9. "8,400-POL-1 Use of Force Reporting and Investigation," Seattle Police Department, last modified September 1, 2024, <https://public.powerdms.com/Sea4550/tree/documents/2042947> (emphasis added).

- Pointing a firearm, Less-Lethal Launcher, or CEW at a person,
- “Displaying the arc” with a CEW as a form of warning, and
- Forcible takedowns that do not result in actual injury or complaint of injury.

NOTE: Escorting, touching, or handcuffing a person with minimal or no resistance does not constitute a Level 1 Use of Force.”¹⁰

Table 1. De minimis force defined in Seattle Police Department Policy Manual

Level of reporting	Threshold	Examples
<p>De minimis Actions that are meant to separate, guide, and/or control, without the use of control techniques that are intended to or reasonably likely to not cause pain or injury.</p>	<ul style="list-style-type: none"> • Physical interactions that are meant to separate, guide, and/or control that are reasonably likely not to cause pain or injury. • Stationary tire deflation device deployment without tire deflation. • Handcuffing discomfort due to the wearing of handcuffs. • Vehicle roadblocks. • Vehicle blocking. 	<ul style="list-style-type: none"> • Using hands or equipment to stop, push back, separate or escort, and the use of compliance holds without the use of sufficient force to cause pain. • Controlled placement/ takedown that does not result in a complaint of pain or disorientation.

Source: “8400-POL-1 Use of Force Reporting and Investigation,” Seattle Police Department, 2 (see note 9).

The Virginia Beach Police Department (VBPD) also restricts the UOFs that its officers must report. Pursuant to its policy, *Reportable Use of Force* is defined as follows:

“any force above hand control or escort techniques (come-along holds) applied for the purposes of handcuffing; or escort techniques that are not used as pressure-point compliance techniques, do not result in injury or complaint of injury, and are not used to overcome resistance.”¹¹

VBSO faces a dual challenge: an expansive definition of RTR and a requirement that every RTR be documented. While erring on the side of caution is arguably positive, this approach places a significant burden on time and resources—particularly given the agency’s current reliance on manual reporting methods. It may not be worth the time and effort deputies spend to generate reports for incidents that, in many other jurisdictions, would not even meet the threshold for a reportable RTR. Moreover, this practice could unintentionally create a misleading public perception that VBSO uses force more frequently than it actually does.

10. “Policy 1115 Use of Force,” Baltimore Police Department, last modified March 11, 2024, <https://www.baltimorepolice.org/transparency/bpd-policies/1115-use-force> (emphasis added).

11. VBPD (Virginia Beach Police Department), “515 Response to Resistance,” General Order, last modified June 16, 2025, <https://police.virginiabeach.gov/your-vbpd/departement-policies>.

Recommendation 1. *The VBSO should revise its definition of Response to Resistance, the criteria for what constitutes a Reportable Response to Resistance, or both. The current definition and reporting requirements are overly expansive, thereby consuming disproportionate staff time and resources. Streamlining these criteria would enable the agency to focus its efforts on incidents warranting closer scrutiny, enhance the clarity and utility of its data, and better align its practices with contemporary law enforcement reporting standards.*

Examples of language that would narrow the definition of reportable RTRs while still ensuring the documentation of actual uses of force can be found in the policies of the Seattle, Baltimore, and Virginia Beach Police Departments, as well as the Harris County (TX) and St. Mary's County (MD) Sheriffs' Offices. Adopting a similar threshold would allow VBSO to maintain appropriate oversight of force incidents without over-capturing routine, low-impact encounters.

This topic is further addressed in the [Policy Review](#) section beginning on page 40.

Lack of Automated Reporting System / Written Reports

The absence of an automated reporting system further exacerbates VBSO's issue of over-capturing incidents. As of this writing, the agency continues to rely exclusively on manual documentation, requiring all personnel involved in an incident to submit written reports through their chain of command. Because many of the basic facts of an incident are contained in written narratives rather than being selected from standardized fields, the completeness and accuracy of each report depend entirely on the involved deputies' accounts and their report-writing skills—resulting in inconsistent documentation of varying quality, clarity, and detail, which can complicate oversight and analysis.

In 2024, the VBSO documented a total of 457 RTR incidents, many of which, as noted, other agencies would not have classified as UOF or RTR. For example, reviewers found that deputies had documented cases in which inmates did not actively resist, but staff believed (based on prior behavior or verbal cues) that they might. Other documented RTRs included actions such as holding an inmate's legs "in case he resisted," or maintaining a grip on an arm while escorting an inmate perceived as potentially noncompliant—even when the inmate offered no actual resistance.

The documentation and report-writing process itself was also problematic. In several incidents, PERF was unable to clearly determine what the RTR entailed, even under VBSO's broad definition. In some reports, it was unclear whether no force had been used (and deputies were exercising caution by generating a report) or force had been used (but not properly documented). In addition, in some instances, it was difficult to determine whether the primary report writer was directly involved in the incident, had witnessed it, or was relaying information from other deputies.

Some reports included vague statements such as “I used CIT skills” or “I attempted to de-escalate the situation,” without specifying the actions the report writer had taken. These phrases alone are insufficient to document de-escalation efforts in an RTR report. Even with future automation, a simple “yes” or “no” in a de-escalation field is not sufficient; deputies must be expected to articulate the specific actions they took or, if none were feasible, the circumstances that prevented de-escalation. As noted in [Training: Report Writing](#), beginning on page 57, teaching VBSO deputies to use the Critical Decision-Making Model (a part of PERF’s Integrating Communications, Assessment, and Tactics program) would help deputies write RTR reports more clearly; it would also assist supervisors in reviewing them.

Beyond the inefficiencies of drafting multiple manual reports of varying degrees of quality, the current system fails to support meaningful data visualization or analysis. This limitation severely restricts internal review, impedes the identification of patterns and areas for improvement, and limits the agency’s ability to present incident data to the public transparently. An automated reporting system that requires users to specify the type of force used (typically from a drop-down menu) and provide a description will reduce ambiguity and improve data integrity.

To its credit, VBSO has been working for several years to implement such a system. However, for various reasons, those efforts have not yet come to fruition. Given the operational and analytical limitations of the current system, implementing an automated solution must now be treated as a strategic priority.

Recommendation 2. *The VBSO must urgently prioritize implementing an automated system to report and document Responses to Resistance. The current process is outdated, inefficient, and duplicative, and it does not support the level of data analysis required to drive meaningful change. Modernizing this system will improve data accuracy, reduce administrative burden, and enable more effective oversight.*

However, automation is only the beginning. VBSO must also ensure its systems capture relevant and actionable data—information the agency genuinely needs to measure and analyze so it can improve its operations—rather than simply collecting data for appearances, without a clear purpose or plan for its use. The focus should be on gathering data that yield meaningful insights and drive decisions. In addition, VBSO should be prepared to adapt its systems as new needs emerge. As the agency begins reviewing cases and data from its automated system, it must remain flexible—ready to incorporate new data fields for information that may not have been initially anticipated but later proves valuable.

The following are examples of data points VBSO may not immediately recognize as essential but which it should consider incorporating into an automated system:

- Currently, VBSO deputies can select only a single incident type on their manual RTR form. It would help if the online form included a “select all that apply” field with a dropdown list. This change would enable VBSO to more accurately capture—and later analyze—the full scope of each RTR incident. For example, in cases where deputies use force to break up a fight between inmates, such a system would permit them to select “Inmate-on-inmate altercation” as well as “Response to resistance” (as well as ensuring that all deputies use the same description of the same type of incident), rather than constraining them to selecting only one incident code.
- VBSO does not currently track instances where deputies remove a person’s clothing by cutting it off. Removing clothing by cutting is an invasive action and a potential source of misconduct allegations. Even if deputies use no other physical force, VBSO should be able to document and explain why they made the decision to remove clothing (e.g., based on their assessment of an individual’s mental state, they removed that individual’s clothing because of concerns about self-harm). Currently, these incidents are captured in the narrative of the RTR form; “Removed clothing by cutting” should instead be a checkbox option, with a supplemental memo if the incident does not otherwise result in the use of force. Having a checkbox will help ensure consistency in capturing these instances and provide a ready means to count and track them.
- VBSO lacks a structured mechanism for documenting what transpires in the aftermath of RTRs, and the automated system may also overlook this area. VBSO should implement a mandatory checkbox or written field requiring deputies to confirm that they offered medical attention, indicate whether a nurse evaluated the individual, and document whether the individual had any observable or reported injuries.

Recommendation 3. *VBSO should strategically evaluate the types of data it collects to ensure they are meaningful, actionable, and aligned with the agency’s operational and oversight goals. The system should be designed with flexibility to evolve, allowing VBSO to incorporate new data fields as needs and priorities shift.*

2024 Response to Resistance

Incident Analysis

There were 457 reported RTR incidents at the VBSO in 2024. PERF analyzed the incidents by examining each report and extracting relevant data points, which are presented in the following sections. As noted in recommendation 2 on page 8, this cumbersome and time-consuming review was necessary because VBSO does not yet have an automated system.

To provide context for some of the RTR data, such as RTRs by race and sex, PERF also reviewed general (non-RTR) information for all individuals incarcerated at VBSO during 2024. This broader review focused on two key metrics:

1. **Bookings (commitments).** The number of times an individual was admitted to the facility between January 1 and December 31, 2024.
2. **Days in custody.** The total number of days an individual spent incarcerated between January 1 and December 31, 2024.

For example:

- *Inmate #1* was booked once in 2024 and remained incarcerated for 10 days. This equates to **1 Booking** and **10 Days in custody**.
- *Inmate #2* was booked five times in 2024, each time for one day. This equates to **5 Bookings** and **5 Days in custody**.

In 2024, there were **14,554 Bookings**¹² at VBCC, resulting in a combined total of **370,368 Days in custody**. This number (370,368 Days-in-custody) represents the cumulative days spent in custody by all individuals incarcerated at VBCC during 2024.¹³

This contextual information provides an important baseline for interpreting the RTR data and, where relevant, will be referenced in the analysis that follows.

Location of Incidents

PERF first analyzed the 457 RTR reports to identify where they occurred.

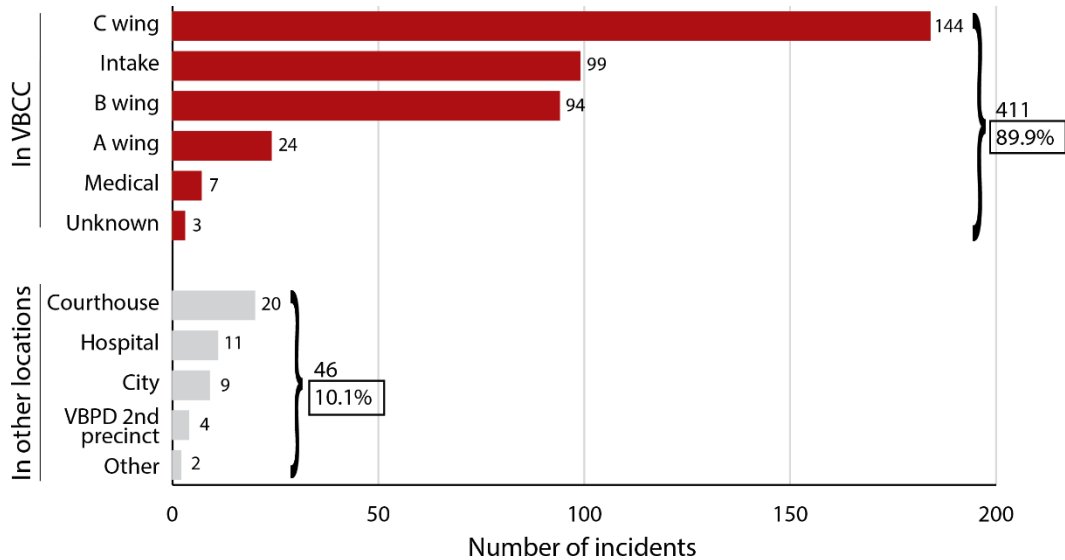
12. This total excludes 36 bookings in which the subject was either designated “I,” which we believe to designate Indigenous people, or “U,” which we presumed to mean unknown. Because this represents a very small portion of the overall bookings and race was a key demographic for analysis, these bookings were omitted.

13. Some **Days-in-custody** counts reflect individuals who were booked into VBCC before January 1, 2024, but remained incarcerated into 2024. For these people, only the days they served on or after January 1, 2024, were included in the calculation.

Incidents outside the VBCC

As shown in figure 1, 10 percent¹⁴ of RTRs (46 incidents) occurred outside of the VBCC.

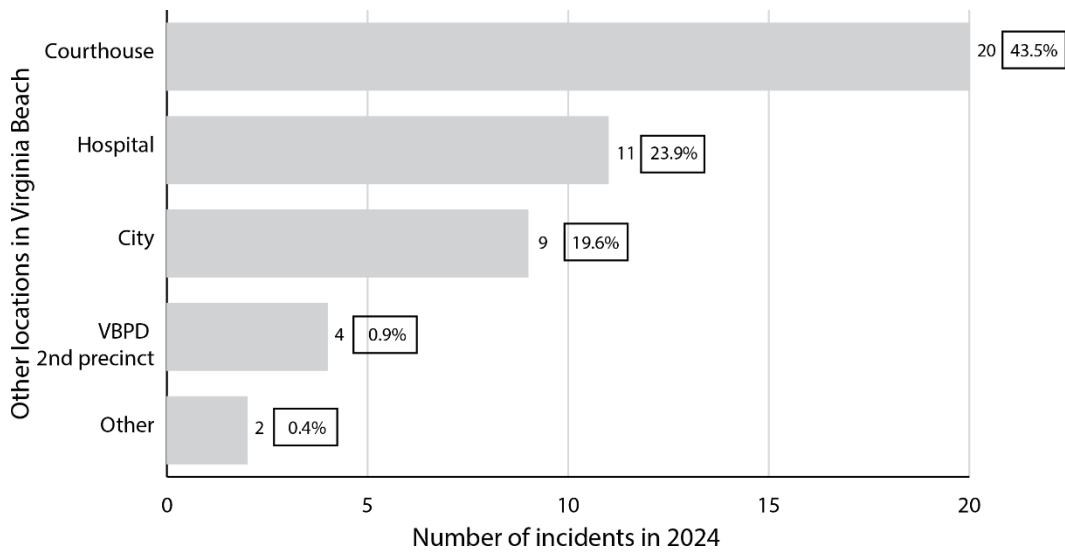
Figure 1. Location of VBSO RTR incidents in 2024 (n=457)



As shown in figure 2 on page 12, these incidents were primarily concentrated at the **Courthouse** (20 RTRs) or in a **Hospital** (11 RTRs)—the two locations outside the jail where deputies are most likely to be with subjects, and where individuals are often emotionally distressed. The courthouse is a setting where legal outcomes may not align with a defendant’s expectations, while hospitals can provoke agitation both before and during medical treatment. This distribution therefore aligns with anticipated patterns given the nature of these environments. The “City”—an all-encompassing description of any location outside of the VBCC that does not have a descriptive name—generated the third-highest number of RTR reports (n=9).

14. Throughout this report, percentages are rounded to the nearest whole number.

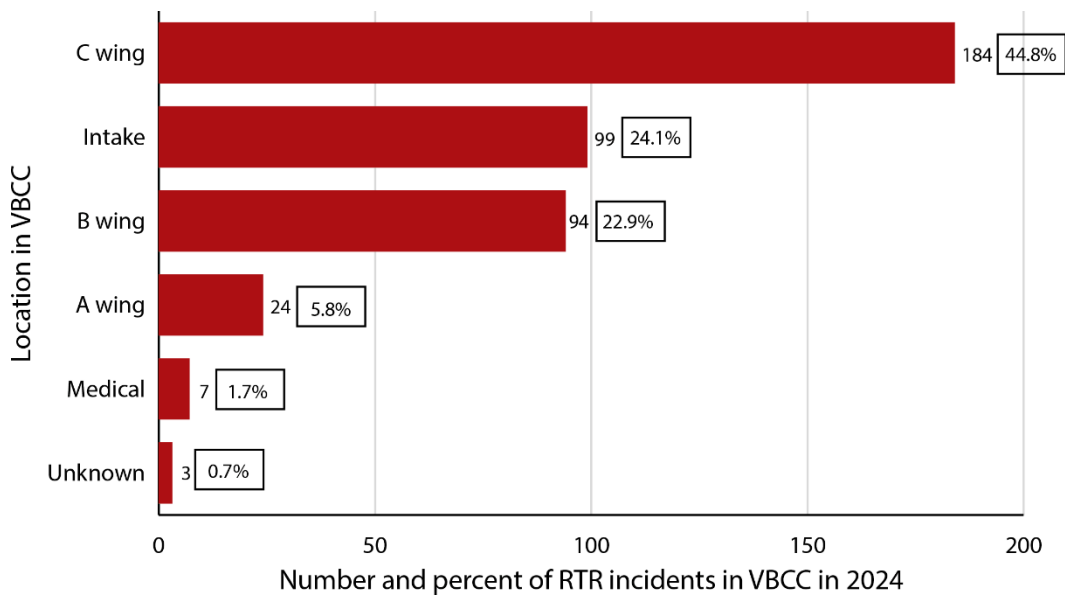
Figure 2. Location of VBSO RTR incidents outside VBCC in 2024 (n=46)



Incidents in the VBCC

The remaining 90 percent of RTRs (411 incidents) occurred inside the VBCC. The distribution of those incidents is illustrated in figure 3.

Figure 3. Location of RTR incidents in VBCC in 2024 (n=411)



The highest number of RTRs occurred in the **C-Wing Housing Unit** (n=184). This location houses male inmates with acute and non-acute mental health conditions, such as schizophrenia, bipolar disorder, and suicidal ideation. Given the population housed in this unit and VBSO's broad criteria for documenting RTRs, this concentration of RTRs is consistent with expectations.

Intake recorded the second-highest number of RTRs (n=99). This is also expected, as every person in the facility must go through intake, and the booking process itself is often emotionally charged. Individuals entering a correctional facility may be angry, intoxicated, resistant, or experiencing heightened stress; sometimes they are experiencing all of these. The high volume of people moving through intake, combined with the stressors involved, increases the likelihood of RTR incidents.

The **B3 Housing Unit** accounted for the third-highest number of RTRs, with 94 incidents; 40 of those occurred in **B3H**. That location includes the female-only restrictive housing areas for women who have violated institutional rules and have been restricted to their cells with no privileges. The fact that RTRs are disproportionately high in that location is not surprising.

Table 2 on page 14 shows a more granular breakdown of where RTRs occurred in the VBCC housing units.

Table 2. RTR incidents in VBCC in 2024 by location (n=411)

VBCC location			Number of RTRs
C			184
	1		1
		N/A	1
	2		92
		D	86
		E	1
		F	2
		N/A	3
	3		86
		A	35
		B	8
		C	8
		D	3
		E	2
		F	27
		N/A	3
	N/A		5
Intake			99
B			94
	1		2
		N/A	2
	2		16
		C	5
		E	1
		F	3
		H	1
		L	1
		N/A	5

VBCC location			Number of RTRs
	3		75
		A	2
		B	2
		C	1
		D	1
		E	1
		F	2
		G	1
		H	40
		J	1
		K	7
		M	8
		N	3
		N/A	6
	N/A		1
A			24
	2		8
		B	2
		F	4
		J	1
		N/A	1
	3		16
		A	2
		C	2
		H	1
		K	2
		L	1
		M	1
		P	1
		Q	2
		N/A	4
Medical			7
Unknown			3

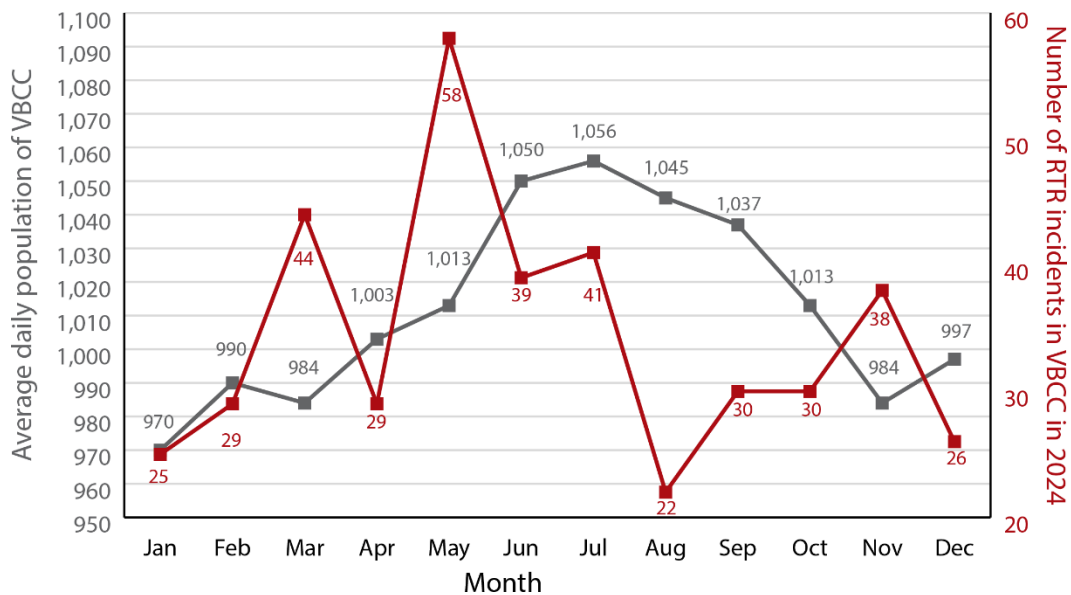
Timing of RTR Incidents

PERF next examined the timing of RTRs, analyzing patterns by **month, day of the week, and hour of the day**.

Monthly

Given that Virginia Beach is a popular summer vacation destination, we anticipated that jail population and RTRs would peak in June, July, and August. The data partially supported that assumption. As shown in figure 4, in the summer months, the VBCC had the highest daily populations: 1,050, 1,056, and 1,045. However, the RTR numbers did not show the same distribution pattern.

Figure 4. Average daily population and actual number of RTR incidents at VBCC in 2024 by month



Instead, as shown in figure 4, the highest number of RTRs occurred in May, with 58 incidents, followed by March with 44 incidents. June and July recorded 39 and 41 incidents, respectively, while August had the fewest incidents of the year, with only 22.

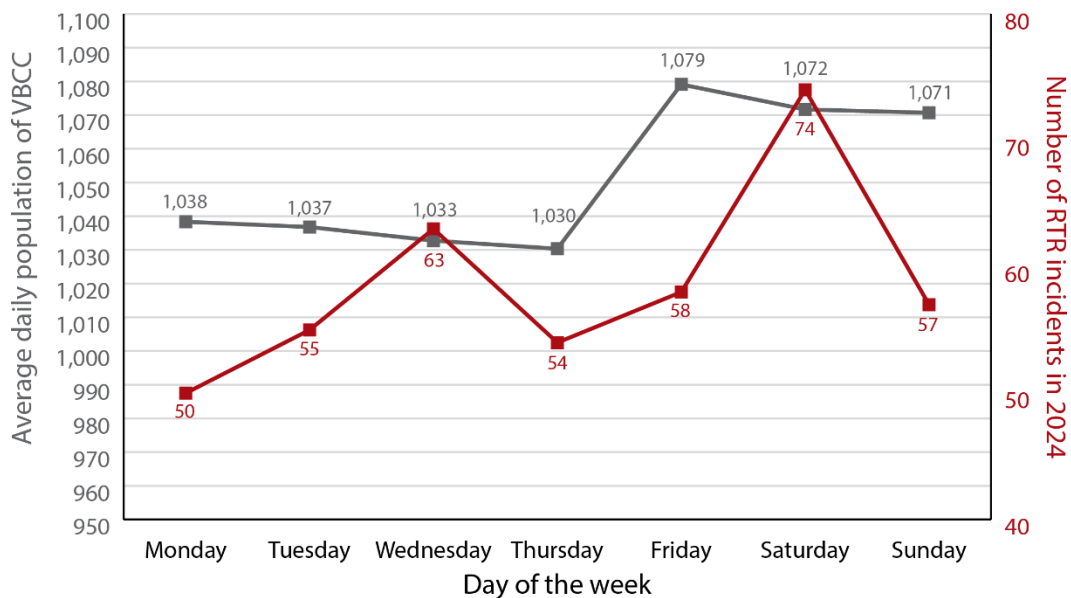
Comparing the daily average population with RTRs therefore reveals some incongruence. August, which had the third-highest daily population, recorded the fewest RTRs. Conversely, May, which ranked in the mid-range for daily population, had the highest number of RTRs.

Because of the lack of historical data systems at VBSO, comparison with previous years is not possible. It is therefore unclear whether this pattern—in which RTRs are misaligned with population numbers—is an anomaly or part of a broader trend. To better inform future staffing and operational planning, VBSO should prioritize tracking and analyzing these data over time.

Day of week

In any community—and especially a beach destination—it seems reasonable to expect that both traffic and recreational drinking and other partying behavior will increase on weekends, and with them law enforcement activity, jail population, and RTR incidents. PERF analyzed VBCC data to determine the distribution of VBCC population and RTR incidents over days of the week in 2024. As shown in figure 5, the population at VBCC did tend to be highest on weekend days, at an average of 1,071 and higher from Friday to Sunday—almost 4 percent higher than the Monday-to-Thursday average of between 1,030 and 1,038. Saturdays also recorded the most RTRs, with 74 incidents throughout the year. Unexpectedly, though, Wednesdays ranked second-highest with 63 incidents, followed by Fridays (58) and Sundays (57). Mondays, Tuesdays, and Thursdays each had between 50 and 55 incidents.

Figure 5. Average daily population and actual number of RTR incidents at VBCC in 2024 by day of the week

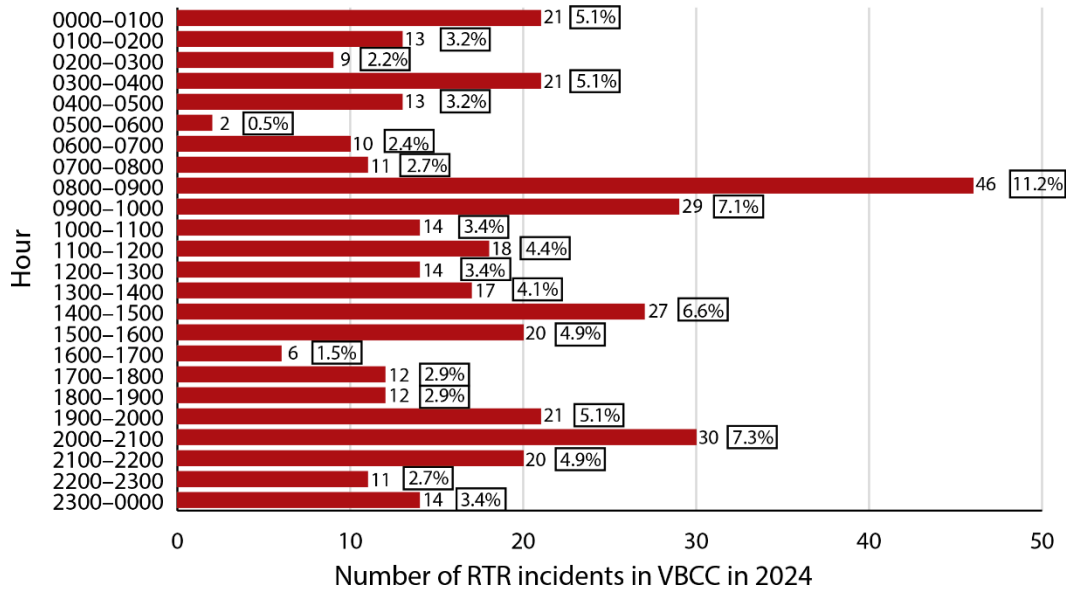


The finding that Wednesdays exceeded Fridays and Sundays in RTRs was somewhat surprising and likely due to random chance. However, as with the monthly analysis, the absence of automated data systems limits our ability to determine whether these patterns represent repeatable trends or chance anomalies unique to 2024. Until VBSO implements structured, searchable data tools, deeper insights will remain out of reach.

Hour of day

Eleven percent of RTRs in the VBCC (46 incidents) took place between 8:00 and 9:00 a.m., as illustrated in figure 6 on page 17. The 8:00–9:00 p.m. hour accounted for the second-highest number of RTRs (30 incidents), followed by 9:00–10:00 a.m. (29 incidents) and 2:00–3:00 p.m. (27 incidents).

Figure 6. RTR incidents at VBCC in 2024 by time of day (n=411)



The 46 incidents recorded in the 8:00–9:00 a.m. hour is 53 percent higher than the 30 incidents documented between 8:00 and 9:00 p.m. To better understand this peak, we examined VBCC’s daily schedule to identify operational factors that might correlate with increased RTR activity during this hour.

- 0000 Kitchen trustees
- 0300 Morning meal commences – lights on
- 0400 Issuance of cleaning gear
- 0600 Head count
- 0630 Razors issued (Saturday only)
- 0800 Cell Inspection – ID check / Head count and housing inspection**
- 0900 Phones / Tablets turn on
- 1000 Lunch meal commences
- 1200 Midday lockdown
- 1400 Midday lockdown concludes
- 1600 Lockdown commences
- 1800 Head count
- 1900 Dinner bags delivered from the kitchen
- 2300 Lockdown-head count/lights dim/phones and tablets off

Between 8:00 and 9:00 a.m., facility staff conduct several compliance-based tasks—cell inspections, identification checks, head counts, and a comprehensive housing inspection. This hour represents the most intrusive daily operational procedure for inmates, requiring them to fully awaken,

stand for ID verification, exit or rearrange their cells, comply with verbal directives, and submit to direct staff interaction. These forced movements and compliance demands can generate significant friction between inmates and staff,¹⁵ and that appears to be the case at VBCC.

This activity occurs immediately after early-morning wakeups and the distribution of cleaning gear, likely contributing to fatigue and irritability among inmates. Furthermore, anticipation of phone and tablet activation at 9:00 a.m. may increase tension and movement in housing units. Collectively, these operational and behavioral factors create conditions that substantially elevate the likelihood of RTRs during this hour.

As with other findings, the 8:00–9:00 a.m. increase in RTRs may represent a 2024 anomaly; however, that rise could also be explained by VBCC operations. To mitigate RTRs during this time frame, VBSO should assess whether additional staff are warranted to manage inspections more effectively, even if this requires shift adjustments. Staff should also be informed that the hour between 8:00 and 9:00 a.m. corresponds with the highest RTR frequency, and deputies should receive targeted refresher training on early-morning de-escalation strategies.

Recommendation 4. *VBSO should evaluate whether its current staffing is sufficient to account for the disproportionate increase in RTRs during the 8:00–9:00 a.m. hour and adjust accordingly. There may be a need for shift adjustments.*

Recommendation 5. *VBSO should ensure staff are fully aware that the 8:00–9:00 a.m. hour represents a disproportionate risk for RTR incidents. Training programs should explicitly incorporate this risk into scenario-based exercises, emphasizing strategies for proactive engagement, heightened situational awareness, and effective de-escalation techniques during this critical period.*

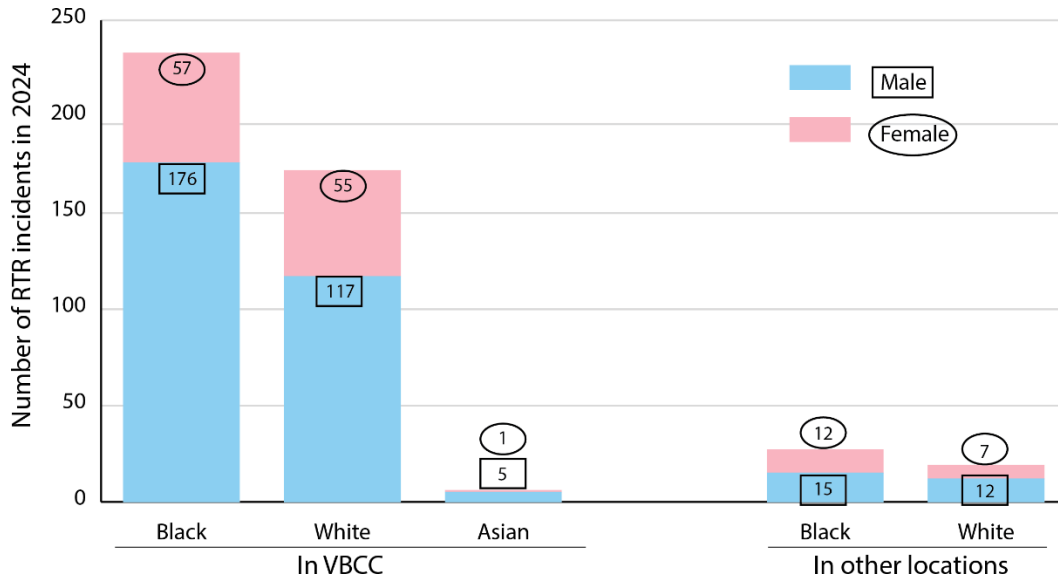
Response to Resistance by Demographics

PERF analyzed VBSO's RTR incidents to understand the demographic breakdown of individuals involved. The results are shown in figure 7. However, it is important to note that VBSO currently tracks only four racial categories: White, Black, Asian, and Indigenous. The agency does not collect data on individuals it identifies as Hispanic or Latino, which limits the accuracy and completeness of its demographic analysis. To better determine which individuals are the subjects of its RTRs, VBSO should begin capturing that data point.

15. Karen F. Lahm, "Inmate Assaults on Prison Staff: A Multilevel Examination of an Overlooked Form of Prison Violence," *The Prison Journal* 89, no. 2 (2009), <https://doi.org/10.1177/0032885509334743>.

Recommendation 6. VBSO should begin collecting data on individuals who identify as Hispanic or Latino. Including this category will improve the quality and completeness of RTR data and help ensure that all demographic groups are appropriately represented in future analyses.

Figure 7. RTR incidents at VBCC in 2024 by subjects' sex and race



Women

According to PERF's review, in 2024, women accounted for the following:

- **Subjects**—24 percent of all individuals booked at VBCC (2,032 of 8,575 individuals booked)
- **Bookings**—24 percent of all VBCC bookings (3,552 of 14,554 bookings)
- **Days-in-custody**—15 percent of total incarceration time (56,262 of 370,368 total days-in-custody)

Breaking down the female population by race shows the following:

- **Black women** represented 10 percent of individuals booked (864 of 8,575 subjects), 10 percent of total bookings (1,455 of 14,554 bookings), and 5 percent of days-in-custody (18,855 of 370,368 total days-in-custody).
- **White women** represented 13 percent of individuals booked (1,148 of 8,575 subjects), 14 percent of bookings (2,072 of 14,554 bookings), and 10 percent of days-in-custody (37,082 of 370,368 total days-in-custody).
- **Asian women** represented 1/5 of 1 percent of individuals booked (20 of 8,575 subjects), slightly more than 1/6 of 1 percent of bookings (25 of 14,554 bookings), and less than 1/10 of 1 percent of days-in-custody (325 of 370,368 total days-in-custody).

Figure 7 on page 19 shows that the number of RTRs in the VBCC involving Black and White women was comparable (57 and 55, respectively). However, White women accounted for roughly twice as many days-in-custody as Black women. This illustrates that in 2024, Black women were involved in RTR incidents at a higher rate than their presence in the facility compared to White women.¹⁶

Importantly, three Black women were repeat RTR subjects who together accounted for 13 incidents—one woman had five RTRs in 2024, and two women had four each. As with other areas of analysis, VBSO’s lack of automation limits the ability to determine whether this imbalance reflects a one-year anomaly, random variation, or a longer-term pattern. Additionally, as noted above, VBSO substantially over-captures RTRs; without a detailed, incident-level review, it is impossible to determine which of the recorded events would even qualify as RTRs under a more common and accurate definition of force.

Regardless, this data point should be monitored by VBSO moving forward.

Recommendation 7. *VBSO should prioritize tracking and evaluating RTRs involving women. Although White women represent a higher average percentage of the VBCC population, Black women are involved in RTRs at a disproportionately higher rate.*

Men

According to PERF’s review, in 2024, men accounted for the following:

- **Subjects**—76 percent of all individuals booked at VBCC (6,543 of 8,575 individuals booked)
- **Bookings**—76 percent of all VBCC bookings (11,002 of 14,554 total bookings)
- **Days-in-custody**—85 percent of total incarceration time (314,106 of 370,368 total days-in-custody)

Breaking down the male population by race shows the following:

- **Black men** represented 39 percent of individuals booked (3,314 of 8,575 subjects), 38 percent of total bookings (5,498 of 14,554 bookings), and 46 percent of days-in-custody (176,026 of 370,368 total days-in-custody).
- **White men** represented 37 percent of individuals booked (3,146 of 8,575 subjects), 37 percent of bookings (5,366 of 14,554 bookings), and 36 percent of days-in-custody (134,624 of 370,368 total days-in-custody).

16. Although RTRs involving Black women outside the facility were also somewhat disproportionately high compared with White women, the number of RTRs was so small in both populations that no statistical conclusions can be drawn.

- **Asian men** represented 1 percent of individuals booked (83 of 8,575 subjects), 1 percent of bookings (138 of 14,554 bookings), and 1 percent of days-in-custody (3,456 of 370,368 total days-in-custody).

While Black men were involved in more RTR incidents (174) than White men (110), this difference aligns with their higher representation in the facility population—though not perfectly. Black men have a slightly higher days-in-custody rate than White men, but the difference is less significant than between the days-in-custody served by Black and White women.

Age

PERF’s analysis showed that the age group with the largest cohort at the VBCC in 2024, whether measured by individuals booked, number of bookings, or days-in-custody, was the group between 30 and 39 years old. This distribution is shown in figure 8.

Figure 8a. VBCC population in 2024 by sex and age—unique individuals booked

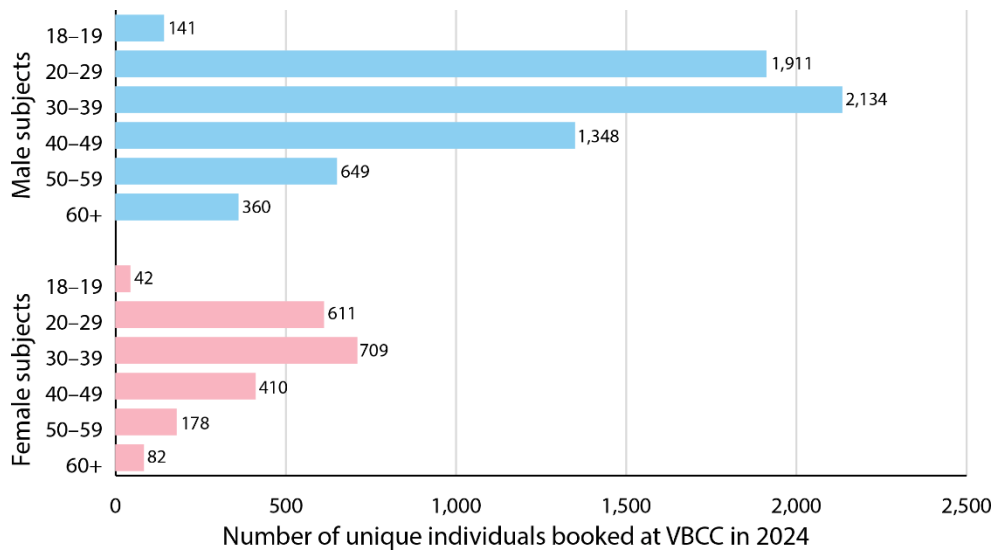


Figure 8b. VBCC population in 2024 by sex and age—number of bookings

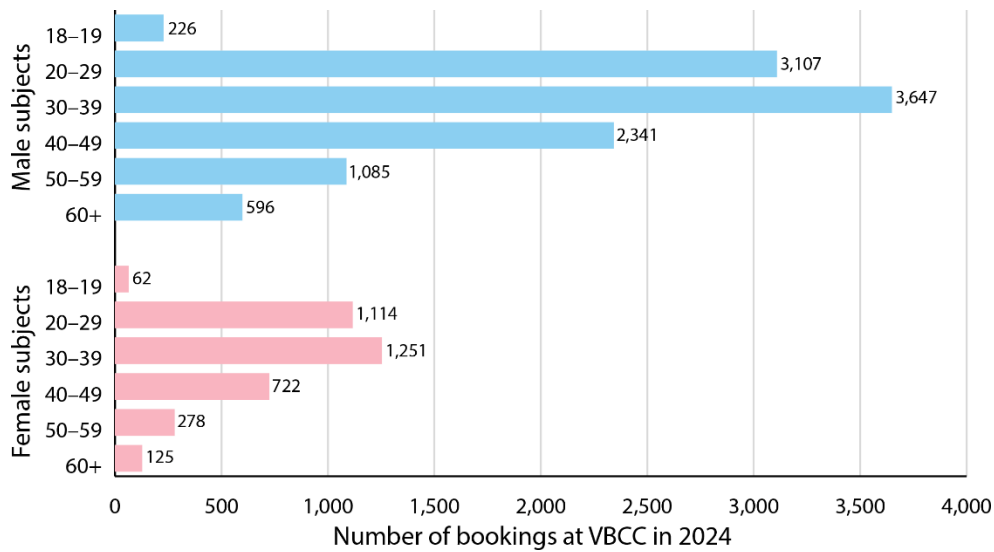
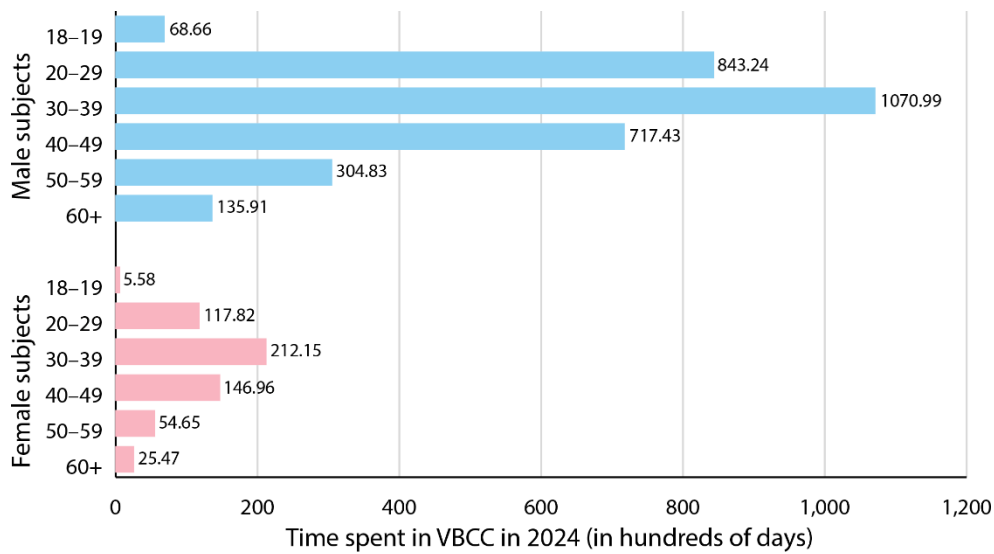


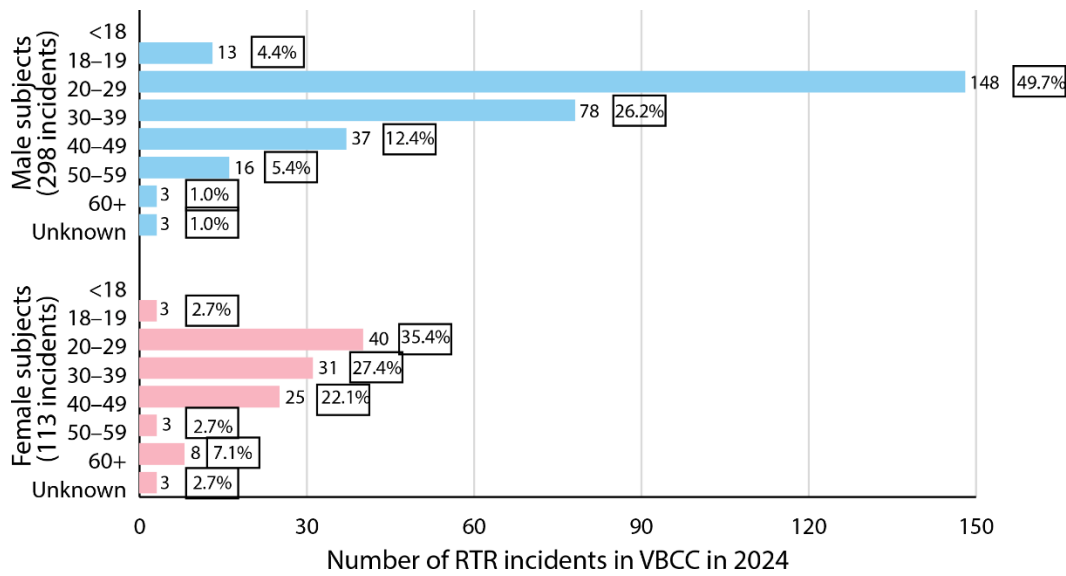
Figure 8c. VBCC population in 2024 by sex and age—days in custody



However, the RTR distribution did not follow the same pattern.

As illustrated in figure 9 on page 23, the age cohort showing the greatest number of RTRs inside the facility was 20–29 for both men and women.

Figure 9. RTR incidents at VBCC in 2024 by subjects' sex and age (n=411)



Among men, those aged 20–29 accounted for roughly half of all RTRs involving male subjects. For women, the percentage was less pronounced (about 35 percent) but still significant.

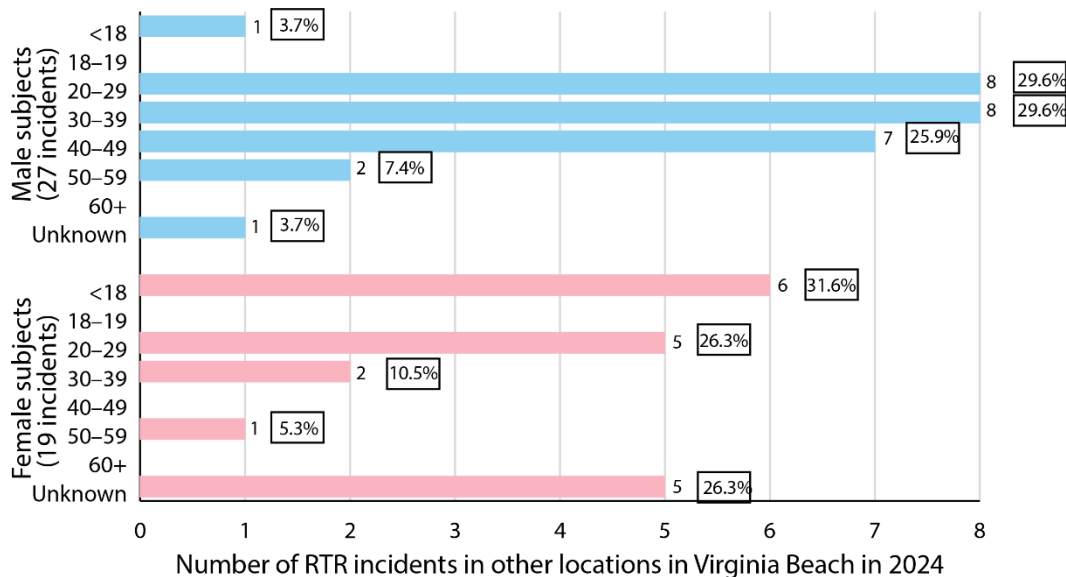
Given the disproportionate representation of men aged 20–29 among RTRs, VBSO should prioritize enhanced scenario-based training focused on this demographic. Research confirms that young men in early adulthood are more likely to exhibit aggressive and combative behaviors than earlier or later in their lives,¹⁷ underscoring the need for proactive strategies. By equipping staff with skills to recognize early warning signs and employ effective de-escalation techniques, VBSO can reduce the likelihood of incidents and improve overall safety in the facility.

Recommendation 8. *VBSO should develop scenario-based training programs that align with the RTR patterns most frequently encountered in the VBCC. Priority should be given to frequent scenarios involving men ages 20–29, as this demographic accounts for nearly half of all RTRs.*

The age distribution for RTRs outside the facility, where there are far fewer RTRs, is presented in figure 10 on page 24.

17. Triana Rego, "Male Antisocial Behavior and Psychological Development: 'Growing Up' and Its Impact on Aggressive Conduct," *Journal of Psychology and Clinical Psychiatry* 5, no. 1 (2016), 9–12, <https://doi.org/10.15406/jpcpy.2016.05.00238>.

Figure 10. VBSO RTR incidents in other Virginia Beach locations in 2024 by subjects' sex and age (n=46)



Response to Resistance Characteristics

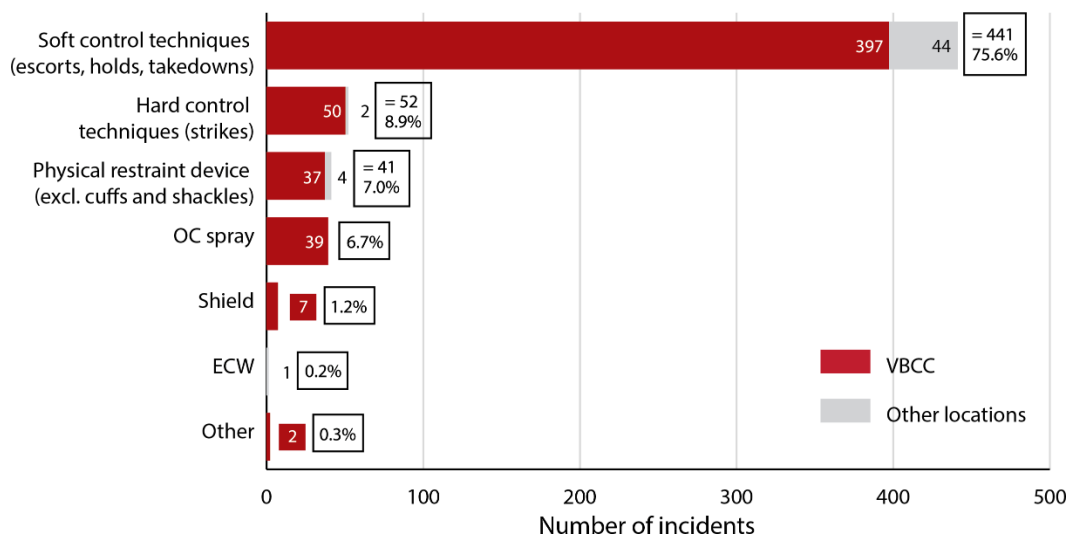
PERF analyzed VBSO’s RTR reports to better understand the types of force used, the individuals upon whom force was applied, and other incident characteristics.

Type of force

To evaluate the level of force used in each incident, PERF categorized RTRs into escalating categories: soft-hand techniques, hard-hand techniques, and device or equipment involved. The last category was further broken down into physical restraint devices, oleoresin capsicum (OC) spray, shield, electronic control weapon (ECW), and other.

In 2024, the VBSO recorded 457 RTR incidents. However, the cumulative count of types of force used totaled 583, because 108 incidents involved more than one type of force. Figure 11 on page 25 provides a detailed breakdown of the various types of force applied across all incidents.

Figure 11. VBSO RTR incidents in 2024 by type of force used



About three-quarters (75 percent) of all RTR reports—both in the VBCC and elsewhere—involved deputies using no more than soft-hand control techniques. These techniques included actions such as escorts, holds, and takedowns, where deputies physically guided or restrained individuals without ever striking them. Some uses were as unintrusive as a deputy holding an inmate’s leg once another deputy had already subdued them. As noted in recommendation 1 on page 7, VBSO’s current reporting practices over-capture RTRs, contributing to the high volume of soft-hand entries.

Subject characteristics

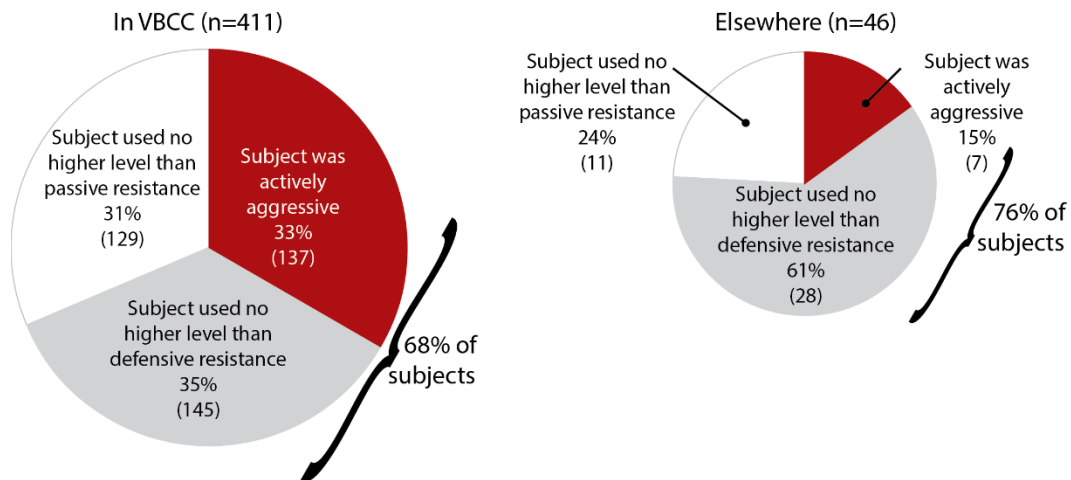
Passive vs. defensive resistance

PERF analyzed the characteristics of individuals involved in RTR incidents, focusing on the level of resistance encountered. Subjects were grouped into three categories:

1. **Passive or less-than-passive resistance.** Behaviors such as verbal noncompliance, refusal to follow commands, or psychological intimidation (e.g., giving a threatening look). These individuals did not engage in any physical resistance.
2. **Defensive resistance.** *Any resistance beyond passive—including physically pulling away, bracing, or actively resisting a deputy’s efforts—but less than active aggression.*
3. **Active aggression.** *Any physically aggressive act directed toward one or more deputies by a subject.*

This categorization allowed PERF to examine how the level of subject resistance correlated with the type of force used. The findings are illustrated in figure 12.

Figure 12. VBSO RTR incidents in 2024 by level of subject resistance



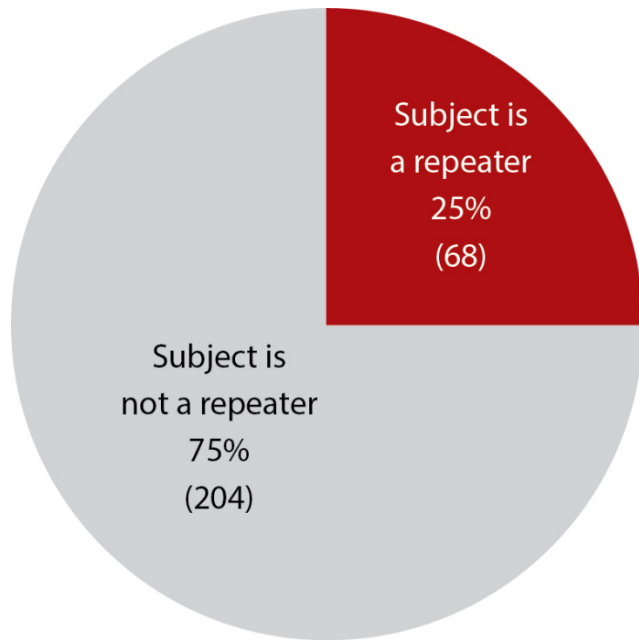
In the VBCC, 68 percent of RTR reports involved subjects exhibiting at least defensive resistance, and 33 percent involved subjects exhibiting active aggression. In locations outside the VBCC, 76 percent displayed at least defensive resistance and 15 percent showed active aggression. The data suggest that at VBSO, force is generally reserved for situations involving subjects displaying more serious levels of resistance.

Subjects involved in more than one RTR incident

PERF analyzed the RTRs to determine the degree to which incarcerated individuals were involved in at least two incidents, identifying these people as “repeat RTR subjects.” As shown in figure 13 on page 27, 25 percent of all subjects involved in RTRs in 2024 were involved in at least one additional RTR during the same year.¹⁸

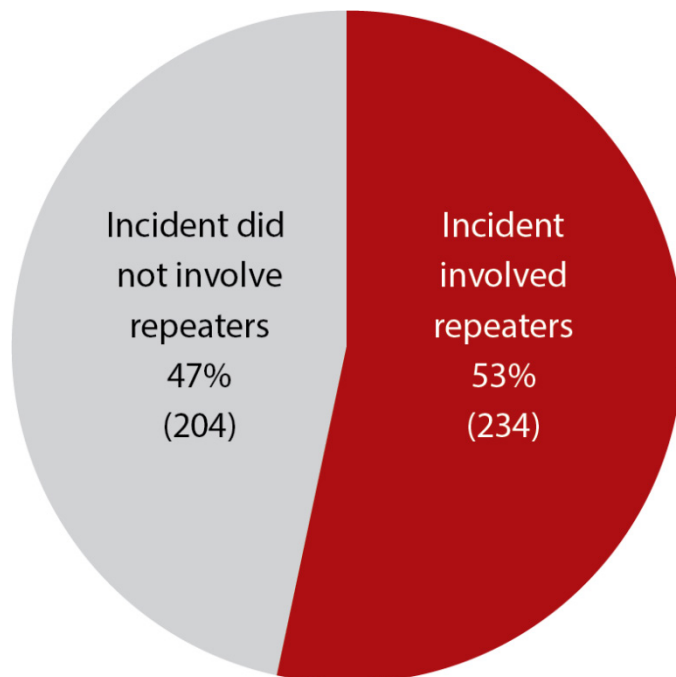
18. For analysis purposes, PERF examined only individuals who were at least 18 years old and had at least one RTR inside the VBCC.

Figure 13. Subjects involved in at least two RTR incidents in VBCC in 2024 (n=272)



Although this group is relatively small—one-quarter of all subjects—they accounted for slightly more than half (53 percent) of all RTRs in 2024, as shown in figure 14.

Figure 14. VBSO RTR incidents in 2024 involving subjects with at least two RTR incidents (n=438)



Further analysis reveals that 14 repeat RTR subjects, each with 5–13 separate RTRs in 2024, accounted for roughly 22 percent of all RTRs. This is a significant finding.

Once RTR tracking is automated, VBSO should implement mechanisms to identify not only whether an individual entering VBCC has prior RTRs but also the nature of those incidents. For example, an RTR involving aggressive resistance due to chronic noncompliance requires a different de-escalation strategy than an RTR involving a person with mental illness who has difficulty understanding and following directions. Leveraging this historical information will enable VBSO to tailor interventions that might reduce future RTRs.

Recommendation 9. *VBSO should establish a process to flag and classify repeat RTR subjects and the nature of prior incidents so that upon their arrival at the VBCC, de-escalation efforts can be planned and tailored to the individual.*

Indicators of subject suicidality

PERF examined the extent to which RTRs were associated with suicidality. This analysis involved (i) identifying individuals who—based on narrative reports—had attempted self-harm, expressed intent to harm themselves, or had been placed on suicide watch, and then (ii) determining whether that suicidality was salient and proximate to an RTR incident. For instance, an inmate on suicide watch who became involved in an RTR after refusing to go to the shower would not be counted as a suicide-connected RTR, because the RTR-triggering behavior (refusal to go to the shower) was unrelated to the suicidality. By contrast, an inmate who verbally expressed a desire to self-harm and was forcibly placed in a restraint chair in response to that expression would be categorized as a suicide-connected RTR because the intervention was directly tied to their suicidal behavior or statements.

It is important to note that VBSO's current intake practice likely inflates the number of individuals classified as suicidal. At present, when a nurse conducts an intake examination and a person refuses to answer all questions, that individual is automatically placed on suicide watch, which requires direct observation—an extremely resource-intensive practice. Direct observation means that one deputy is assigned to continuously monitor one inmate. While this level of supervision is appropriate for individuals who present a genuine risk of suicide, it may not be necessary for those who are simply uncooperative, angry about incarceration, and unwilling to answer questions. Put another way, a person's refusal to answer a question should not automatically be considered an indication that they present a danger to themselves.

VBSO should revise its intake protocol to ensure suicide watch placement is based on observable indicators of suicidality rather than blanket application of suicide watch any time a person refuses to answer questions. Specifically, VBSO should do the following:

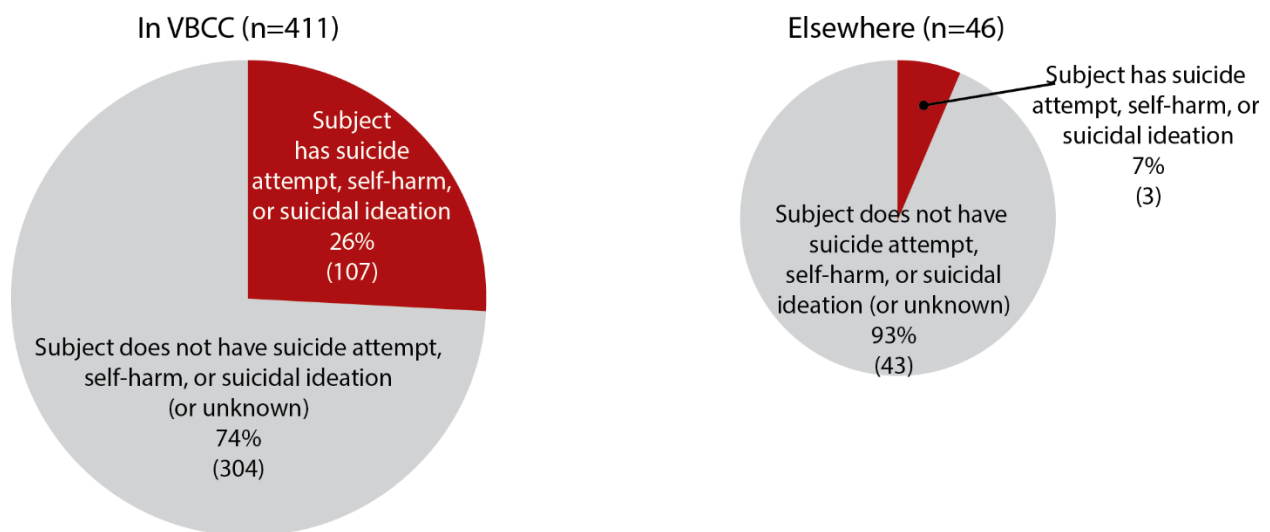
- **Collaborate with medical and mental health staff** to review current practices and identify criteria that more accurately reflect suicide risk.
- **Implement a tiered observation system** for individuals who refuse to answer all intake questions but show no signs of suicidality. Options could include enhanced monitoring or temporary placement in a location with improved visibility.

This approach will maintain inmate safety while improving the allocation of staff and resources.

Recommendation 10. *VBSO should work with its medical and mental health practitioners to develop a more nuanced intake process for individuals who refuse to answer all intake questions. Automatically placing every such person on suicide watch is inefficient and may divert resources from inmates who are at genuine risk. A tiered observation system—tailored to how the individual is presenting—would likely function more effectively, but these determinations should be made in coordination with local medical and mental health professionals.*

The results of the analysis of RTRs and their connection to inmates displaying signs of suicide or self-harm are presented in figure 15.

Figure 15. VBSO RTR incidents linked to subjects displaying signs of self-harm or suicidality in 2024



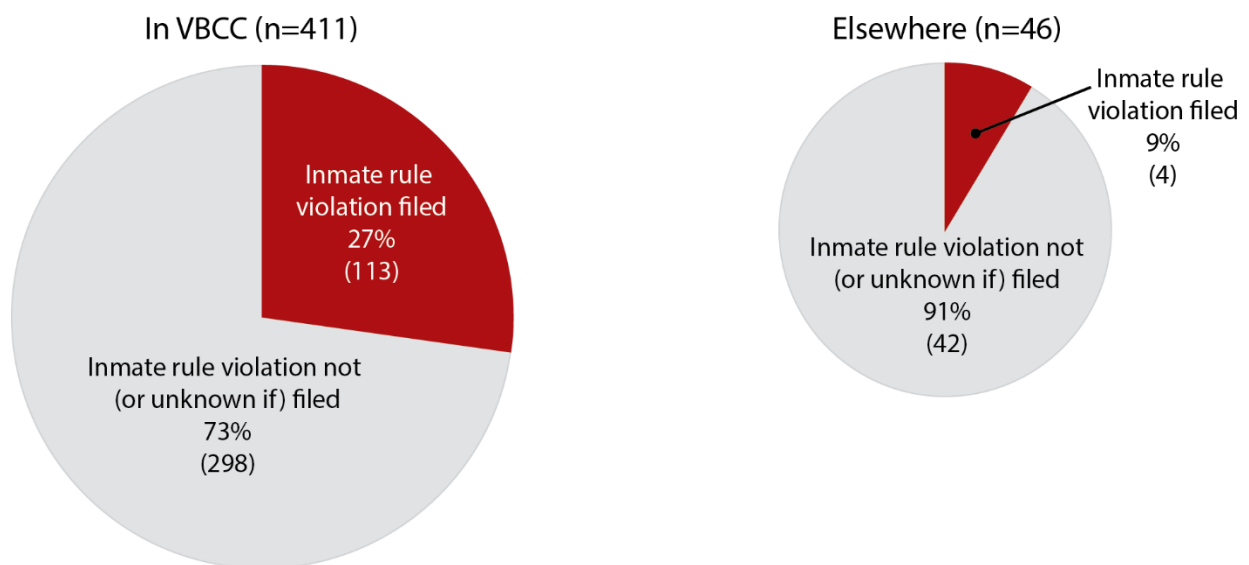
In the VBCC, 26 percent of RTRs involved individuals who were on suicide watch or had expressed or demonstrated a desire to harm themselves. This figure dropped to 7 percent in areas outside the correctional facility.

The significantly higher proportion of RTR incidents involving individuals with suicidality inside VBCC than outside suggests that the emotional distress and restrictive conditions associated with incarceration likely contribute to these encounters. It also reflects the unfortunate fact that a disproportionate percentage of any incarcerated population is composed of people with mental illnesses, some of whom will be suicidal.

Subject rule violation

PERF examined the number of subjects written up for rule violations following the RTR incident. The most frequently cited violations were variations of failure to comply with a direct order and disorderly conduct. These findings are illustrated in figure 16.

Figure 16. Inmate rule violations cited after VBSO RTR incidents in 2024

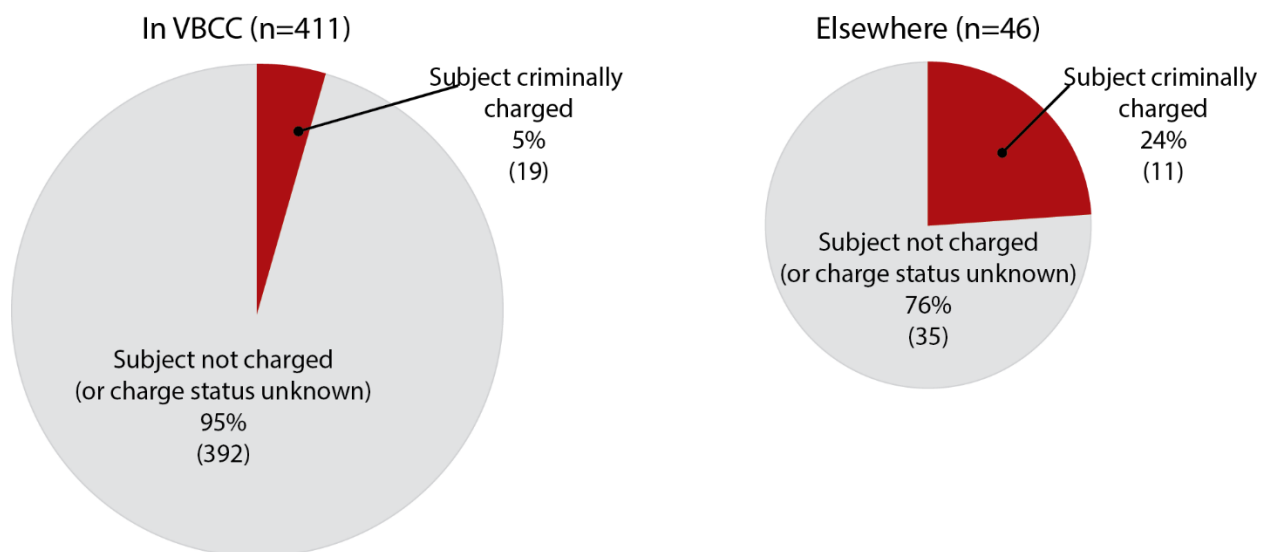


In the facility, subjects were cited for rule violations following 27 percent of RTR incidents, compared with just 9 percent outside the facility. But given that nearly every RTR involves some form of noncompliance, every RTR could (at least potentially) be accompanied by a rule violation in the subject's file, the low rate at which deputies actually file rule violations suggests that they do not issue citations gratuitously, vindictively, or any time they use any level of force. (At the same time, this low rate of rule violation filing also underscores the relatively minor nature of the incidents that currently trigger RTR reporting at VBSO.)

Subjects charged with crimes

PERF also analyzed how many RTR incidents resulted in criminal charges against the subject, such as assault on a deputy. As seen in figure 17 on page 31, deputies charged subjects with crimes after only 5 percent of incidents that took place in the VBCC. That percentage grew to 24 percent for incidents that occurred outside the facility.

Figure 17. VBSO RTR incidents resulting in criminal charges against subjects in 2024



Lower charging rates inside the facility than outside

As with the small percentage of subjects cited for rule violations in the facility, the low number of individuals charged with crimes further reinforces the notion that deputies are not overreacting to subject noncompliance. Instead, these figures suggest that criminal charges are appropriately reserved for incidents involving serious and unambiguously criminal conduct, rather than being a routine outcome of RTR events. Notably, there were instances in which deputies who were clearly injured victims nonetheless documented in their RTR reports that they were declining to pursue charges because of the subject’s mental illness.

The increase to 24 percent (11 incidents) outside the facility is likely driven by several factors. First, deputies are more likely to pursue charges for minor offenses committed in public than for similar behavior in the facility, because such conduct carried out in public view has broader safety implications than in the facility, where it can be handled administratively through disciplinary measures or cell placement rather than criminal charges. In addition, external environments are far less controlled than the correctional setting, and subjects outside the jail are more likely than those inside to escalate resistance or engage in criminal acts—that is, to commit offenses that would warrant criminal charges no matter where they occurred. These conditions, collectively, likely contribute to the higher rate of criminal charges following RTRs outside the facility.

Overall interpretation

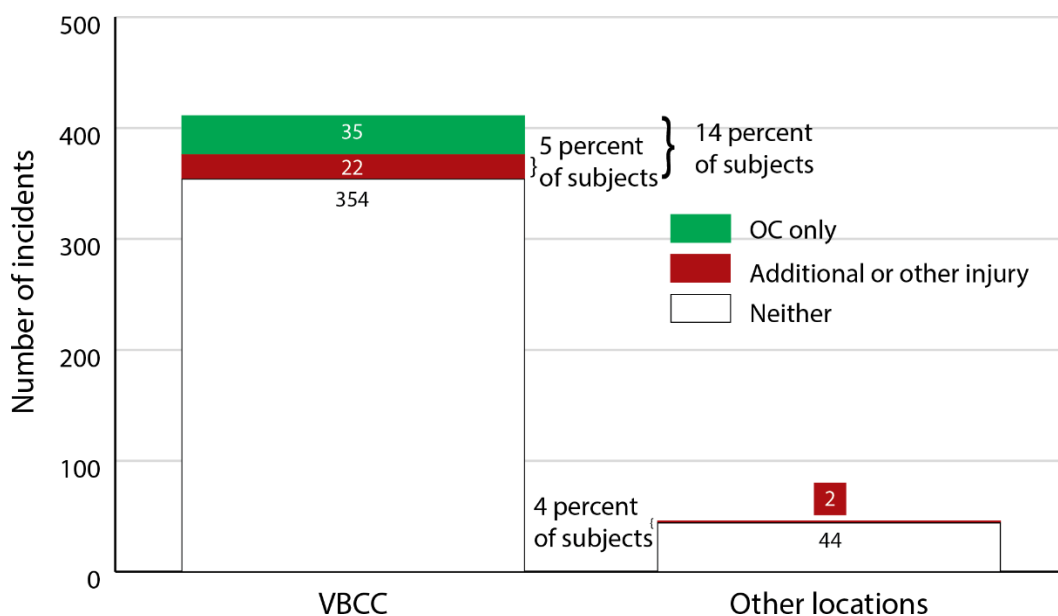
This analysis also supports the broader conclusion that most RTR incidents at VBSO involve relatively minor infractions and that deputies exercise restraint in both the UOF and the decision to pursue formal charges.

Injuries to deputies and subjects

PERF analyzed all RTRs to determine how frequently subjects and deputies sustained injuries in connection with those incidents. For an individual to be classified as “injured,” they needed to have documented or visibly apparent evidence of an ailment, deformity, or wound or direct exposure to OC spray. Importantly, the presence of a “connected injury” does not imply that the RTR itself was the proximate cause of that injury. For example, several non-OC spray injuries were related to acts of self-harm rather than to deputies’ actions. However, if an injury was present and occurred in the context of the RTR event, it was counted as connected.

As shown in figure 18, 14 percent of subjects in the VBCC sustained injuries in connection with an RTR. When cases involving only OC spray exposure are excluded, the percentage of injured subjects drops to 5 percent. The percentage of subjects injured in connection with RTRs outside the facility was approximately 4 percent.

Figure 18. VBSO RTR incidents resulting in documented subject injury in 2024

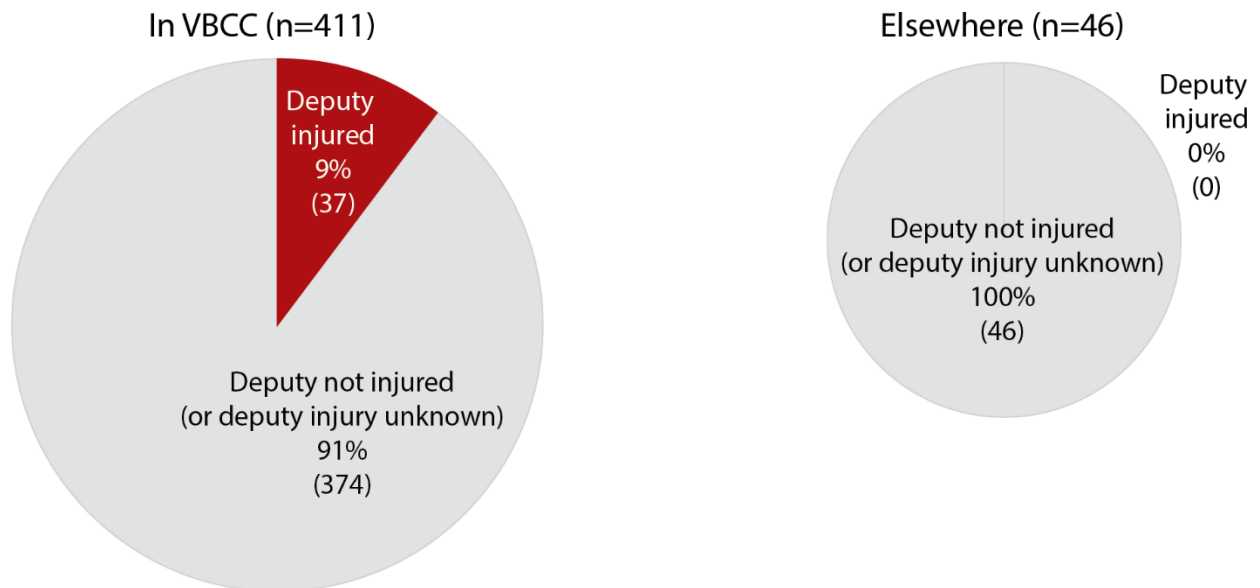


Inside and outside the VBCC, the subject injury rates are very low. This is particularly notable given the subject fatality incident that prompted this review; it suggests that subject injuries associated with RTR events at the VBSO are relatively uncommon.

The only manner by which VBSO currently captures deputy injuries is through Workers’ Compensation–related injury forms. Accordingly, if a deputy is injured but not to the extent that they are filing for benefits or find it worth the time and effort to complete the forms, those injuries are not reflected in the RTR reports. Therefore, deputy injuries are likely underrepresented.

The percentage of *incidents* in which one or more deputies were injured in connection with an RTR is illustrated in figure 19.¹⁹

Figure 19. RTR incidents resulting in documented VBSO deputy injury in 2024



In the VBCC, 9 percent of RTRs resulted in a deputy injury, while outside the facility, there were no documented deputy injuries. When PERF did see injuries to deputies, they tended to be mostly minor scrapes; twists, strains, and bruises; and occasionally something more serious like a bite.

Whether or not a deputy is injured during an RTR should not rest upon whether they choose to spend time completing Workers' Compensation forms. When VBSO automates, it should ensure that there is a box for "deputy injury" along with space for a brief explanation. This will help VBSO more accurately track a valuable data point.

Recommendation 11. *VBSO should ensure that, once automated, it tracks deputy injuries in a way that more accurately captures whether those engaged in RTRs are physically harmed. The current method does not allow for meaningful analysis and likely undercounts deputy injuries.*

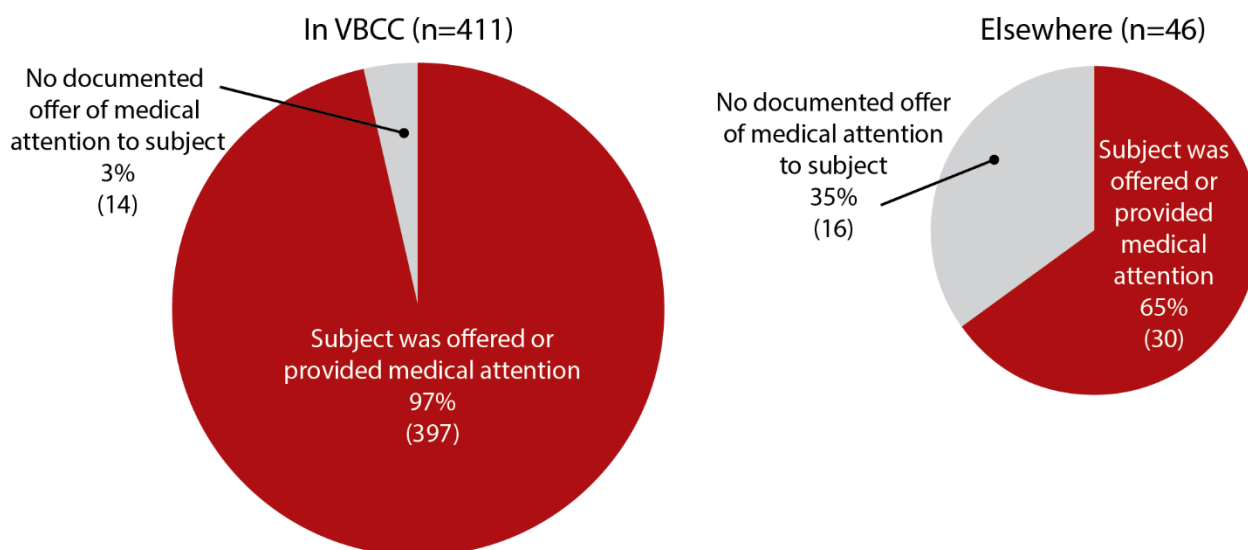
19. This figure likely underestimates the actual *number* of deputies who were injured, as some may have sustained injuries but did not document them.

Subject offered medical assistance

Pursuant to Section 2(E) of VBSO’s RTR policy, “Following the application of any force . . . a deputy shall use best efforts under the circumstances to provide or arrange for proper decontamination and/or the provision of medical help *as necessary*” (emphasis added). The “as necessary” language grants deputies discretion to determine whether and how to provide or arrange medical assistance or decontamination based on the situation.

PERF reviewed RTR reports to assess how often subjects were offered or provided medical assistance. However, these findings—as shown in figure 20—should be interpreted with caution. Deputies may have offered medical aid but not documented those offers in their self-generated narratives. This documentation gap should be resolved once VBSO implements an automated reporting system that includes a checkbox for “Medical attention offered or provided.”

Figure 20. Documented instances of subjects offered or provided medical assistance following VBSO RTR incidents in 2024

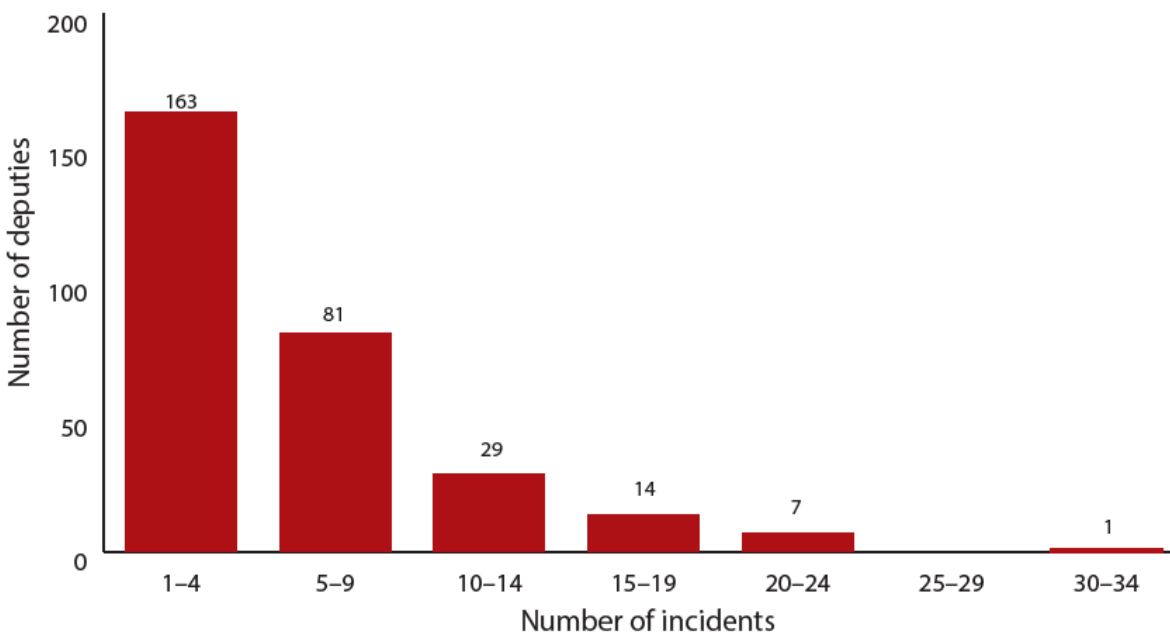


Although medical assistance was offered or provided in almost all instances, PERF recommends that VBSO update its policy to *require* deputies to, at a minimum, offer medical assistance after any application of force. [See recommendation 21 on page 47.] This policy update will be especially important after VBSO changes and tightens its definition of force to exclude minor incidents that do not normally constitute force.

Deputy involvement

PERF analyzed the incidents to determine how RTRs were distributed across personnel. Those results are shown in figure 21.

Figure 21. VBSO deputies involved in RTR incidents in 2024



Some of VBSO’s nearly 400 deputies at VBCC had no RTRs in 2024. Among the 295 deputies involved in at least one RTR that year, the vast majority had four or fewer. At the other end of the spectrum, 7 deputies had 20–24 incidents, and one deputy had 34 RTRs.

In any correctional facility, assignments in areas where individuals are more likely to experience heightened anxiety—such as intake units or housing areas with residents managing mental health conditions—can reasonably be expected to produce more RTRs. Conversely, assignments during midnight shifts on standard housing floors, when most people are asleep, would typically produce fewer RTRs.

For that reason, PERF will avoid making broad generalizations about deputies’ overall use of force. However, certain figures (20–24 RTRs) stand out as concerning, and one in particular (34 RTRs) is exceptionally high. While the current definition of force is quite broad—often requiring deputies to document even minor actions—more than 20 RTRs in a single year is significant and warrants significant examination.

As with other issues connected to documenting force at VBSO, the lack of automation likely precludes in-depth, year-over-year analysis. Most large, modern agencies have some type of early warning or early intervention system to alert when UOFs by members are high. As with other

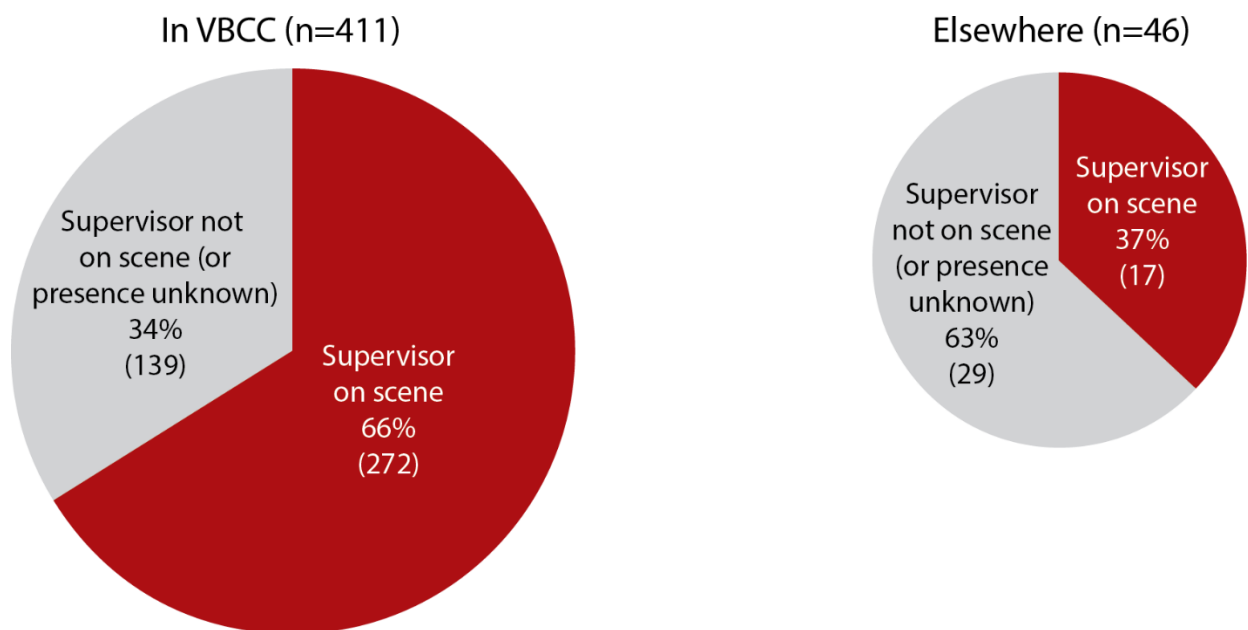
aspects of VBSO’s “hard-copy” outdated and un-automated system, any such mechanism to alert supervisors when deputies use force in disproportionately high numbers is not yet practical. [See [Early Intervention System](#) beginning on page 61.]

General RTR characteristics

Supervisor on scene

PERF reviewed RTR reports to determine how often supervisors were present on scene. The results are shown in figure 22.

Figure 22. Supervisors on scene at VBSO RTR incidents in 2024



A supervisor was present for approximately two-thirds of RTR incidents that occurred inside the VBCC. For incidents outside the facility, supervisor presence dropped to 37 percent. This difference is understandable.

As noted in the [Location of Incidents](#) section beginning on page 10, intake accounts for a disproportionately high number of RTR incidents, and a supervisor is assigned to that area. Other high-incident locations within the facility—such as the mental hygiene block—are generally contained to specific housing units. If an incident begins to escalate in these areas, deputies can quickly radio for assistance, allowing supervisors to respond promptly. In contrast, incidents occurring outside the facility present logistical challenges. Supervisors are less likely to be nearby and cannot respond as quickly, which explains the lower on-scene presence for these incidents.

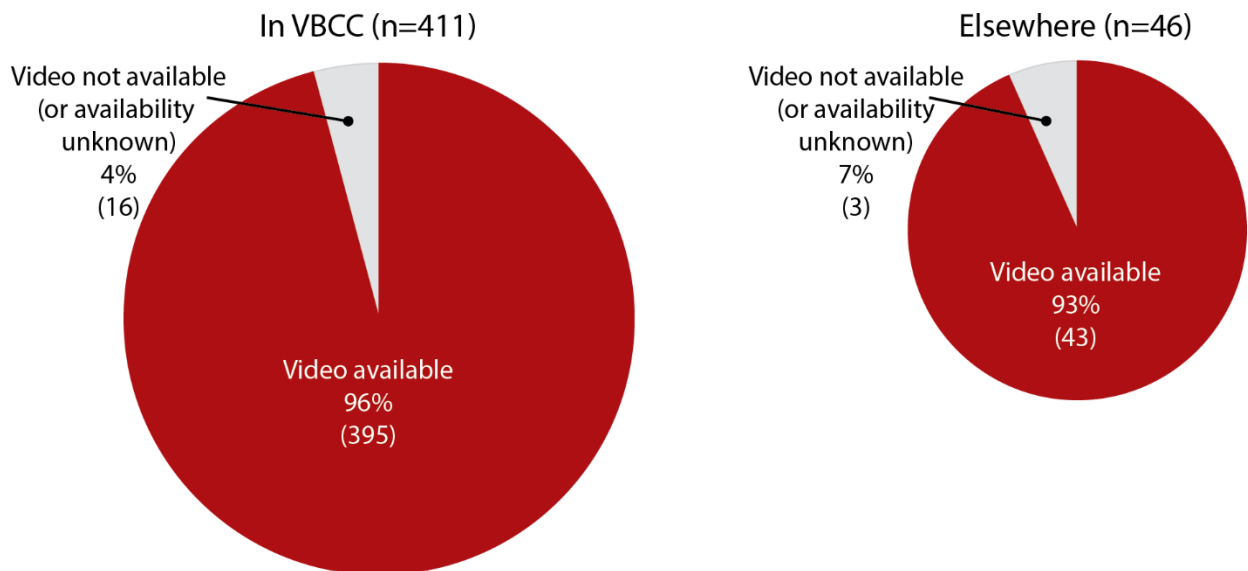
Availability of video

Because VBSO does not have an automated system for tracking video, PERF assessed whether footage of RTR incidents existed using three indicators:

1. A statement in the report—typically at the end—indicating whether a body-worn camera (BWC) was activated
2. A notation in the file that the writer reviewed the hallway camera
3. A statement noting that a supervisor reviewed video footage (without noting the type of camera)

As seen in figure 23, nearly all RTRs in 2024 were captured on video.

Figure 23. Availability of video of VBSO RTR incidents in 2024



Of the 457 RTR reports reviewed, only 19 lacked a written indication that video footage existed. VBSO BWCs include a two-minute lookback feature—longer than the 30–60 seconds most agencies provide—that allows deputies to activate their cameras and capture events up to two minutes prior to activation. Combined with facility cameras, this capability enabled video review in approximately 96 percent of incidents in 2024. This figure represents an exceptionally high rate of video documentation, reflecting VBSO’s strong commitment to transparency.

Video remains an essential tool for ensuring accountability. As VBSO considers revising its definition of RTR to exclude minor incidents where no actual force is used, the agency should maintain its emphasis on comprehensive video documentation and work toward achieving 100 percent video availability.

Property damaged during incident

PERF reviewed incidents to assess whether property was damaged during the incident, defining damaged property as actual physical harm or destruction—excluding minor soiling or damage to items of minimal value. Some examples of actual property damage (generally deputies' personal property rather than inmates', whose belongings were less likely to be present or affected—other than when clothing is cut off, as discussed earlier) included a watch, a radio, and a tablet issued to an inmate. The analysis, displayed in figure 24, showed that these types of incidents were very rare in the facility and did not occur outside it.

Figure 24. VBSO RTR incidents in 2024 during which property was damaged



Moving Forward – Response to Resistance Transparency

Currently, VBSO lacks an automated system to capture RTR data, resulting in a manual, labor-intensive review process. As noted in recommendation 2 on page 8, implementing an automated system should be a top priority for the VBSO. In today's operational environment, automation is essential for both efficiency and accountability.

Once VBSO adopts such a system and can accurately capture relevant RTR data, the agency should consider creating and maintaining a Use-of-Force Transparency Portal on its website. This portal would allow the public to view and understand the frequency and context of force incidents at VBSO. Including additional information—such as facility demographics and the training initiatives VBSO uses to minimize force—would provide valuable context and reinforce public trust.

VBSO can look to other sheriffs' offices, such as San Mateo County, California,²⁰ or King County, Washington,²¹ for models of effective transparency portals.²² Taking this step would further demonstrate VBSO's commitment to openness and accountability.

Recommendation 12. *After implementing an automated data-capture system and ensuring accurate, contextually relevant RTR data, VBSO should consider publishing this information on its website through a publicly accessible use of force portal.*

20. "Use of Force Data," San Mateo County Sheriff's Office, accessed December 15, 2025, <https://stage.smcsheriff.com/transparency-portal/use-of-force-data>.

21. "Use of Force," King County, WA, accessed December 15, 2025, <https://kingcounty.gov/en/dept/sheriff/about-king-county/about-sheriff-office/news-data-reports/use-of-force>.

22. Law enforcement agencies in Virginia with robust use of force portals include the Norfolk and Fairfax County Police Departments. "Police Data Hub," City of Norfolk, accessed January 21, 2026, <https://www.norfolk.gov/5750/Police-Data-Hub>; "FCPD Reports," Fairfax County Police Department, accessed January 21, 2026, <https://www.fcpcod.org/pages/fcpd-reports>.

Policy Review

Transparency

Through its policies, VBSO demonstrates a strong commitment to modern standards in law enforcement and correctional care. However, those policies are not available online.

Publishing policies and general orders online is a key component of transparency. It enables the community to understand the expectations the agency places on its personnel and provides a clear reference point when community members have questions and issues. Public access to these documents also helps contextualize officer conduct, allowing the public to assess whether their actions align with agency standards.

Moreover, making policies readily available, rather than providing them only upon request, empowers public officials to engage openly with the communities they serve. It signals a commitment to accountability and builds trust.

VBSO may find value in looking to its neighboring agency, VBPD, which makes its policies publicly available online as part of its transparency efforts.²³ Other examples include the Montgomery County (MD) Sheriff's Office²⁴ and the Volusia County (FL) Sheriff's Office.²⁵ Adopting a similar approach could further support VBSO's ongoing commitment to openness and community trust.

Recommendation 13. *The VBSO should make its policies and general orders publicly accessible online. This action would demonstrate the agency's commitment to transparency and help build trust with the community it serves.*

Use of Force

The decision to use force is significant; it requires continuous assessment of the situation, threats, options, and risks, with the overarching goal of resolving all encounters peacefully.

The PERF team reviewed VBSO policies related to UOF for thoroughness and compliance with recognized policing practices. PERF also examined whether VBSO's policies provide deputies with a clear understanding of the agency's rules, expectations, and guidelines regarding UOF.

23. "Department Policies," City of Virginia Beach Police Department, accessed September 30, 2025, <https://police.virginiabeach.gov/your-vbpd/departments-policies>.

24. "Montgomery County Sheriff's Office Policies," Montgomery County, accessed January 21, 2026, <https://www.montgomerycountymd.gov/sheriff/policies.html>.

25. "Transparency and Use of Force," Volusia County Sheriff's Office, accessed January 22, 2026, <https://www.volusiaheriff.gov/transparency.stml#>.

Specifically, PERF reviewed the following:

- General Order 11-01-00: Response to Resistance (Use of Force)
- General Order 11-02-00: Weapons Policy
- General Order 11-05-00: Use of Restraint Equipment

In addition, PERF reviewed four other policies that, while not directly related to UOF, are high-liability policies that can ultimately affect UOF.

1. General Order 08-13-00: Arrest/Detention and Handling of Juveniles
2. General Order 10-06-00: Felony Screening Procedures
3. General Order 11-05-00: Use of Restraint Equipment
4. General Order 13-01-00: Intake and Intake Classification Process

To begin with, VBSO should consider consolidating all force-related policies into a single, comprehensive document organized into clearly defined sections rather than maintaining multiple separate policies. This approach would streamline access and improve usability. Based on PERF's experience, officers consistently prefer having all force-related guidance in one location for ease of reference. For example, the VBPD consolidates all force-related directives into a single overarching Use of Force/Response to Resistance policy.²⁶ The VBSO should consider doing the same.

Recommendation 14. *VBSO should consider consolidating all force-related policies into a single, comprehensive document organized by clearly defined sections.*

In addition, as VBSO implements PERF's recommendations for modifications to its UOF policies, the agency should present those modifications to its members and then incorporate them into future UOF training modules. Specifically, VBSO should present updated policies to its sergeants first, followed by its deputies.

Recommendation 15. *After implementing PERF's UOF policy recommendations, VBSO should present the revised policies to sergeants first and then to deputies with an overview training session. Moving forward, training on all aspects of force should reflect the new policies. Where possible, this training should include a scenario-based component that allows deputies to apply their training to real-life situations.*

26. VBPD, "515 Response to Resistance" (see note 11).

PERF's National Role in Shaping Use of Force Standards

PERF's review of VBSO's UOF policies, training, and practices comes at a time of heightened national scrutiny. Since 2010, PERF has convened hundreds of police leaders and experts to develop actionable strategies to reduce unnecessary force. This work has produced widely adopted principles and training programs that help agencies move beyond compliance toward prevention and accountability.

Much of PERF's work focuses on police interactions with people who are unarmed or are armed with weapons other than firearms and who are behaving erratically or dangerously because of a mental health crisis, drug addiction, disability, or other condition. When police encounter an individual displaying a firearm, their options are limited. However, when there is no firearm, officers generally have more opportunities to slow the situation down and use communication skills and defensive tactics to buy time, build trust, and defuse the situation without resorting to force.

PERF has issued the following reports detailing these principles:

- *15 Principles for Reducing the Risk of Restraint-Related Death* (2024) - Guidance on minimizing harm during physical restraint.*
- *Suicide by Cop: Protocol and Training Guide* (2019) - Tools for recognizing and responding to suicide-by-cop scenarios.†
- *ICAT: Integrating Communications, Assessment, and Tactics* (2016) - Scenario-based training for defusing critical incidents.‡
- *Guiding Principles on Use of Force* (2016) - 30 foundational recommendations for modern UOF policy.§
- *Re-Engineering Training on Police Use of Force* (2015) - A call to overhaul outdated training models.**
- *Defining Moments for Police Chiefs* (2015) - Leadership insights for navigating high-stakes decisions††

PERF's *Guiding Principles* report is the core document of this work, providing 30 recommendations, including the following:

- **Policy & Ethics**
 - The sanctity of human life should be at the heart of everything an agency does.
 - Police use of force must meet the test of proportionality.
 - Prohibit deadly force against individuals who pose a danger only to themselves.
- **Training & Response**
 - Adopt de-escalation as a formal agency policy.
 - Scenario-based training should be prevalent, challenging, and realistic.
 - Provide a prompt supervisory response to critical incidents.
- **Tactics & Tools**
 - Use distance, cover, and time to replace outdated concepts like the "21-foot rule."
 - The Critical Decision-Making Model offers a structured approach to incidents.
 - Duty to intervene: Officers must prevent excessive force.
 - Promptly render first aid to respect the sanctity of life.

PERF's training program, ICAT: Integrating Communications, Assessment, and Tactics, provides officers with the tools, skills, and options they need to implement the Guiding Principles and to safely defuse a range of critical incidents. ICAT training has been independently studied and has been associated with decreases in the use of force and in injuries to officers and citizens alike.**

* PERF (Police Executive Research Forum), *15 Principles to Reduce the Risk of Restraint Related Death* (Washington, DC: Police Executive Research Forum, 2024), <https://www.policeforum.org/assets/Restraint.pdf>.

† PERF *Suicide by Cop: Protocol and Training Guide* (Washington, DC: Police Executive Research Forum, 2019), <https://www.policeforum.org/assets/SBCTrainingGuide.pdf>.

‡ PERF, *ICAT: Integrating Communications, Assessment, and Tactics. A Training Guide for Defusing Critical Incidents* (Washington, DC: Police Executive Research Forum, 2016), <http://www.policeforum.org/assets/icattrainingguide.pdf>.

§ PERF, *Guiding Principles on Use of Force* (Washington, DC: Police Executive Research Forum, 2016), <https://www.policeforum.org/assets/guidingprinciples1.pdf>.

** PERF, *Re-Engineering Training On Police Use of Force* (Washington, DC: Police Executive Research Forum, 2015), <https://www.policeforum.org/assets/reengineeringtraining1.pdf>.

†† PERF, *Defining Moments for Police Chiefs* (Washington, DC: Police Executive Research Forum, 2015), <https://www.policeforum.org/assets/definingmoments.pdf>.

‡‡ Robin S. Engel et al., "Assessing the Impact of De-Escalation Training on Police Behavior: Reducing Police Use of Force in the Louisville, KY Metro Police Department," *Criminology & Public Policy* 21, no. 2 (2022), 199–233, <https://doi.org/10.1111/1745-9133.12574>.

General Order 11-01-00 Response to Resistance

General Order 11-01-00, Response to Resistance, serves as VBSO's primary UOF policy. PERF found the policy to be well-developed and aligned with many contemporary UOF principles. However, there are opportunities to fortify the policy. The following section highlights key strengths of VBSO's current policy and provides targeted recommendations to enhance its alignment with emerging best practices.

General Order 11-01-00 – Notable strengths

VBSO's RTR policy has many strengths that are often lacking in comparable agencies' policies. PERF highlights the following notable elements:

- **Integration of PERF's 15 Principles for Reducing the Risk of Restraint-Related Death.** VBSO has proactively incorporated key recommendations into its policy. For example, whenever possible, a designated **Safety Officer**²⁷ must be assigned prior to any RTR or UOF event [GO 11-01-00 Sec. 2(I)]. This officer is responsible for monitoring the subject's well-being throughout the incident and intervening if necessary. The fact that VBSO implemented this measure prior to PERF's review reflects its attention to force reform and correctional care.
- **Continuous monitoring requirement.** All deputies are required to continuously monitor a subject's condition during and after restraint [GO 11-01-00 Sec. 2(H)].
- **Dedicated de-escalation section.** The policy includes a clear section on de-escalation strategies, such as slowing the pace of engagement; using time, distance, and available cover; and employing verbal persuasion [GO 11-01-00 Sec. 3].
- **Proportional UOF.** Deputies must apply force that is reasonable and proportionate to the threat or resistance encountered and are required to immediately reduce the level of force as the threat diminishes or ceases [GO 11-01-00 Sec. 3].
- **Duty to intervene.** The policy clearly states that any deputy who observes another using excessive force must promptly intervene, provide aid if needed, and report the incident [GO 11-01-00 Sec. 7].
- **Firearm aiming defined as deadly force.** The act of aiming or pointing a firearm is explicitly categorized as a use of deadly force [GO 11-01-00 Sec. 8(A)].
- **Restrictions on shooting at moving vehicles.** Deputies are prohibited from firing at a moving vehicle unless an occupant is actively using or threatening deadly force by means other than the vehicle or the vehicle is being used as a weapon of mass destruction [GO 11-01-00 Sec. 8(H)].

27. PERF (Police Executive Research Forum), "8. Designate a Patient Safety Officer," *15 Principles for Reducing the Risk of Restraint-Related Death* (Washington, DC: Police Executive Research Forum, 2024), 13, <https://www.policeforum.org/assets/Restraint.pdf>.

These provisions reflect a thoughtful and progressive approach to UOF. The following sections outline opportunities for additional improvement to this policy.

General Order 11-01-00 - Policy statement

General Order 11-01-00's current policy statement outlines VBSO's overarching philosophy on UOF/RTR. While the current policy statement provides a foundational framework, PERF recommends enhancing it by incorporating explicit language that emphasizes three core principles: **sanctity of human life, de-escalation, and proportionality.**

Emphasizing the sanctity of human life

As PERF noted in *Guiding Principles on Use of Force*, "The sanctity of human life should be at the heart of everything an agency does."²⁸ In that vein, VBSO's policy statement should clearly affirm its commitment to preserving life and treating all individuals with dignity and respect. Strengthening this language would reinforce the agency's dedication to ethical policing and help build trust with the community.

Examples from other agencies include the following:

- **The Chicago Police Department:**
"Sanctity of Human Life. The Department's highest priority is the sanctity of human life. The concept of the sanctity of human life is the belief that all human beings are to be perceived and treated as persons of inherent worth and dignity, regardless of race, color, sex, gender identity, age, religion, disability, national origin, ancestry, sexual orientation, marital status, parental status, military status, immigration status, homeless status, source of income, credit history, criminal record, criminal history, or incarceration status. Department members will act with the foremost regard for the preservation of human life and the safety of all persons involved."²⁹
- **The Washington (D.C.) Metropolitan Police Department:**
"Members . . . shall value and preserve the sanctity of human life at all times, especially when lawfully exercising the use of force."³⁰

Recommendation 16. *VBSO should incorporate a clear and prominent policy statement at the beginning of its UOF policy affirming the sanctity of human life. This statement should set the tone for the entire policy and reflect the agency's commitment to respectful, accountable, and community-centered policing.*

28. PERF, "Principle 1," *Guiding Principles on Use of Force* (Washington, DC: Police Executive Research Forum, 2016), 34, <https://www.policeforum.org/assets/guidingprinciples1.pdf>.

29. Chicago Police Department, "De-Escalation, Response to Resistance, and Use of Force," General Order G03-02, last modified June 28, 2023, <https://directives.chicagopolice.org/#directive/public/6214>.

30. "Use of Force," *General Order 901.07* (Washington, DC: Washington Metropolitan Police Department, 2024), <https://mpdc.dc.gov/page/written-directives-general-orders>.

Integrating de-escalation as a foundational principle

Although General Order 11-01-00 (section 3) includes a detailed discussion of de-escalation techniques, the current policy statement does not reference this critical component. PERF recommends revising the statement to explicitly highlight de-escalation as a preferred and tactically sound approach whenever feasible.

An example from another agency is as follows:

The Baltimore Police Department:

“De-Escalation. Members shall use De-Escalation Techniques and tactics to reduce any threat or gain compliance to lawful commands without the Use of Force or with the lowest level of force possible (See Policy 1107, *De-Escalation*).”³¹

Recommendation 17. *VBSO should incorporate language into its UOF policy statement that highlights de-escalation as a core element of its overall approach. The statement should make clear that de-escalation not only is encouraged but also is often the most effective and appropriate response in high-stress situations.*

Affirming proportionality in UOF

Finally, PERF recommends that VBSO include the principle of proportionality in its policy statement. This inclusion would reinforce the expectation that deputies use only the level of force necessary to respond to a given threat and continuously reassess the situation.

An example from another agency follows:

The Washington (D.C.) Metropolitan Police Department:

“In situations where the use of force is justified, the utmost restraint should be exercised. Members shall minimize the force that is used while protecting the lives of members and other persons, and continuously reassess the perceived threat in order to select the reasonable use of force response that is proportional to the threat faced by him, her, or others.”³²

Recommendation 18. *VBSO should incorporate language into its UOF policy statement that affirms proportionality as a guiding principle. The statement should emphasize that officers are expected to use only the level of force necessary to respond to a given threat and to continually reassess the situation to ensure their response remains appropriate and justified.*

31. “Use of Force,” *Policy 1115* (Baltimore, MD: Baltimore Police Department, 2024), <https://www.baltimorepolice.org/transparency/bpd-policies/1115-use-force>.

32. “Use of Force,” *General Order 901.07* (see note 30).

General Order 11-01-00 - Definitions

In fact, to enhance clarity and consistency in applying its RTR policy, VBSO should consider adding formal definitions for key concepts such as **de-escalation** and **proportionality**. While these principles are used throughout the policy, their absence from the definitions section could lead to ambiguity in interpretation and implementation.

De-escalation

Although General Order 11-01-00 includes a dedicated section on de-escalation strategies, the term itself is not formally defined. A clear definition would help ensure consistent understanding and application across the agency. The following language, adapted from the Buffalo (NY) Police Department's UOF policy, is an example of such a definition:³³

"De-Escalation Techniques are actions taken by members that are designed to eliminate the need to use force in order to resolve any event or situation."

Once defined, VBSO can expand upon the concept in the relevant (de-escalation) section of the policy to reinforce expectations and best practices.

Recommendation 19. *VBSO should include a formal definition of de-escalation in the Definitions section of General Order 11-01-00.*

Proportionality

Proportionality guides deputies to consider the nature and severity of a situation and apply only the level of force necessary to address the threat. It also emphasizes the importance of continually reassessing the situation as it evolves. Importantly, proportionality does not require officers to pause and consider public perception in the moment, but rather to act reasonably and responsibly in response to the threat presented.

While VBSO's policy reflects the principles of proportionality, a formal definition would reinforce its importance and clarify expectations. The following definition, taken from the New Jersey Office of the Attorney General's statewide policy, could be adapted:

Proportional Force. The minimum amount of force, of both type (e.g., physical, mechanical, or deadly) and intensity, that is necessary to control a situation and achieve a legitimate law enforcement objective. The law permits officers to overcome unlawful force or resistance; thus, the term proportional force is not intended to mean a type and intensity of force that is exactly equal to the type and intensity of force being used by the subject.³⁴

33. "General Order No. 2019-010 Use of Force," Buffalo Police Department, last modified 2019, <https://www.bpdny.org/31/Resources>.

34. *Use of Force Policy* (Trenton: Office of the New Jersey Attorney General, 2025), <https://www.njoag.gov/force/>.

Recommendation 20. *VBSO should include a formal definition of proportionality in the definitions section of its UOF policy.*

Provision of medical assistance

As noted in the **Subject Offered Medical Assistance** section beginning on page 34, General Order 11-01-00 (2)(e) currently states, “Following the application of any force . . . a deputy shall use best efforts under the circumstances to provide or arrange for proper decontamination and/or the provision of medical help *as necessary*” (emphasis added). This “as needed” language grants deputies broad discretion in determining whether medical assistance is required.

Once VBSO updates its definition of RTR, this provision should be similarly revised. After any RTR, deputies should be required to offer medical assistance to the subject and to document the subject’s response. This change will strengthen both safety practices and accountability.

Recommendation 21. *VBSO should revise the RTR policy to require that “after any response to resistance, deputies must offer medical assistance to the subject.”*

Deployment of less-lethal weapons

General Order 11-01-00 (4) provides limited guidance on the deployment of less-lethal weapons. More detailed and comprehensive language on this topic is found in General Order 11-02-00 – Weapons Policy.

To improve clarity and consistency, PERF recommends consolidating relevant content from GO 11-02-00 into a restructured and unified UOF policy. As noted in recommendation 15, combining all force-related directives into a single, thorough document would reduce ambiguity and ensure deputies have access to clear, consistent guidance. For example, the VBPD includes its weapons policy in its comprehensive RTR policy.³⁵

Recommendation 22. *VBSO should remove the limited language on less-lethal weapons currently found in GO 11-01-00 (section 4) and incorporate the full content of GO 11-02-00 into a revised, comprehensive UOF policy.*

If VBSO opts to maintain separate policies, PERF recommends removing the current language in section 4 and instead directing deputies to the dedicated Weapons Policy for guidance.

Reporting and documenting force

General Order 11-01-00 (11) - Reporting and Documentation - governs how RTR incidents are reported and documented.

35. VBPD, “515 Response to Resistance” (see note 11).

As discussed in recommendation 1 on page 7, VBSO should revise its definition of RTR, adjust the criteria for what qualifies as a reportable RTR, or implement both changes. PERF's review found that many documented incidents involved minimal or benign contact—which, while technically meeting VBSO's current definition of RTR, would not have been classified as reportable UOFs by most other agencies.

Currently, section 11(A) requires deputies to report any RTR to a supervisor, and sections 11(B), (C), and (D) require all involved deputies to submit detailed reports even for minor incidents. This practice consumes significant time that could be better spent on core responsibilities related to inmate care and oversight.

Consistent with recommendation 1, VBSO should modify section 11 to reflect common practices in other agencies' UOF policies. To align with common practices in other agencies, in addition to the verbiage modifications recommended in the **Definition of "Response to Resistance" and Reportable Uses of Force** section on pages 4–7, VBSO could also consider updating the definition of RTRs, retaining the requirement that all RTRs be reported to a supervisor (section A) but limiting formal documentation to incidents involving the following:

- Force exceeding basic push or pull methods used to escort or direct a subject exhibiting little or no resistance
- The pointing of an ECW at an individual as a threat of force
- The use of a lethal weapon, a less lethal weapon, or a weapon of opportunity
- Any instance where injury is observed or alleged by the subject
- *Any incident where the supervisor, at their discretion, directs documentation*

Maintaining the requirement that all RTRs be reported to a supervisor—and granting supervisors discretion to require documentation—would provide an effective system check after revising the definition of RTR itself.

Recommendation 23. *VBSO should consider modifying General Order 11-01-00(11) to remove the blanket requirement that every involved deputy must document every use of force. Instead, documentation could be required for the following:*

- *Force exceeding basic push or pull methods used to escort or direct a subject exhibiting no or little resistance*
- *The pointing of an ECW at an individual as a threat of force*
- *The use of a lethal weapon, a less-lethal weapon, or a weapon of opportunity*
- *Any instance where injury is observed or alleged by the person who was subject to an officer's UOF*
- *Any incident where the supervisor, at their discretion, directs it*

Board of inquiry

General Order 11-01-00 (12)(B) notes, “The sheriff or [their] designee may also convene a board of inquiry to examine an incident in which force was applied. The board of inquiry will ascertain training, policy, and equipment needs.”

PERF recommends that VBSO formalize the board of inquiry process to *require* convening for all serious UOF (SUOF). VBSO can define which incidents it wishes to classify as SUOFs, but can consider adapting the New Orleans Police Department’s definition, which includes the following:

- All uses of lethal force
- All critical firearm discharges
- All uses of force resulting in serious physical injury or requiring hospitalization
- All neck holds
- All uses of force resulting in a loss of consciousness
- All canine bites
- More than two applications of [a] CEW on an individual during a single interaction, regardless of the mode or duration of the application, and whether the applications are by the same or different officers, or CEW application for 15 seconds or longer, whether continuous or consecutive
- Any strike, blow, kick, CEW application or similar use of force against a handcuffed subject³⁶

Recommendation 24. *VBSO should modify General Order 11-01-00(12)(B) to require that the sheriff or their designee convene a board of inquiry after every serious use of force.*

General Order 11-02-00 Weapons Policy

General Order 11-02-00 Weapons Policy governs the use of both lethal and less-lethal tools. As noted in recommendation 14 on page 41, PERF recommends eliminating General Order 11-02-00 as a standalone directive and integrating its contents into General Order 11-01-00. This consolidation would support the creation of a single, comprehensive policy encompassing all UOF directives.

While PERF found GO 11-02-00 to be strong, there are areas for improvement.

Policy statement

General Order 11-02-00 includes a policy statement regarding the authorization, issuance, and carrying of weapons. If VBSO chooses to retain this order as a separate policy, it should incorporate the policy statement from General Order 11-01-00—revised in accordance with PERF’s recommendations. Specifically, the revised statement should emphasize the principles of **sanctity of life** (see

36. “Chapter 1.3, Use of Force,” *New Orleans Police Department Operations Manual* (New Orleans: New Orleans Police Department, 2022), <https://nola.gov/next/nopd/topics/policies/>.

recommendation 16 on page 44), **de-escalation** (see recommendation 17 on page 45), and **proportionality** (see recommendation 18 on page 45) to reinforce VBSO's overarching philosophy on UOF and RTR.

Recommendation 25. *If VBSO maintains separate policies related to UOF, it should incorporate the policy statement from General Order 11-01-00 into the weapons policy. This statement should explicitly include the concepts of sanctity of life, de-escalation, and proportionality.*

Absence of definitions

General Order 11-02-00 lacks a definitions section. If VBSO chooses to maintain separate policies related to UOF, it should incorporate the definitions section from General Order 11-01-00 into the weapons policy. (Our recommendations for the definitions of de-escalation and proportionality should be incorporated into these definitions.)

In doing so, VBSO should ensure that key terms—particularly **de-escalation** (see recommendations 17 on page 45 and 19 on page 46) and **proportionality** (see recommendations 18 on page 45 and 20 on page 47)—are clearly defined. Including these definitions will help reinforce consistent understanding and application of core principles across all force-related policies.

Recommendation 26. *If VBSO elects to retain separate UOF policies, it should integrate the definitions section from General Order 11-01-00 into the weapons policy. This section should explicitly include definitions of de-escalation and proportionality to ensure alignment with best practices and the agency's philosophy.*

“Taser Energy Weapons”

In VBSO's current policy, ECWs are referred to as “Taser Energy Weapons” (TEW). However, the term **electronic control weapon (ECW)** (or, in some agencies, conducted energy weapon or conducted electrical weapon (CEW)) is the widely accepted standard across the law enforcement profession. To ensure consistency with industry norms and improve clarity, VBSO should update its terminology accordingly.

Recommendation 27. *VBSO should replace all references to “Taser Energy Weapons” and “TEW” with the widely accepted generic term “electronic control weapon” or ECW.*

“Taser Energy Weapon Pre-Deployment”

This section of the policy outlines guidance for deputies before deploying an ECW. To enhance situational awareness and promote safety, VBSO should revise this section to require, whenever feasible, that before deploying an ECW a deputy issue a verbal warning both to the subject and to nearby deputies.

Issuing a verbal warning serves several important purposes:

- It gives the subject an opportunity to comply voluntarily.
- It alerts other deputies to the intended action.
- It reinforces principles of de-escalation and transparency.

Recommendation 28. *VBSO should modify its policy language and practice to require that, whenever feasible, a deputy give a verbal warning both to the subject and to other nearby deputies before deploying an ECW.*

Multiple simultaneous deployments

VBSO's current policy does not address the issue of multiple simultaneous ECW activations. To promote safety and prevent unnecessary or excessive force, VBSO should revise its policy to explicitly prohibit the intentional deployment of more than one ECW against a subject at the same time. This clarification would support coordinated responses and align VBSO with widely accepted best practices in UOF policy.

Recommendation 29. *VBSO should add language to its policy stating, "Personnel shall not intentionally activate more than one ECW at a time against a subject."*

Drive Stun

The current policy states:

"The use of the Drive Stun is not prohibited; however, because of its decreased effectiveness due to its localized effect, it is discouraged, unless it involves exigent circumstances where a standard deployment is impractical. The Drive Stun can be used to complete a circuit."

PERF recommends that VBSO revise this language to clarify the definition and appropriate use of Drive Stun mode. Specifically, the policy should discourage its use as a pain compliance technique and emphasize its limited tactical role.

Recommendation 30. *VBSO should revise the Drive Stun section to state, "Drive Stun mode shall be used only to supplement probe mode to complete the incapacitation circuit or as a countermeasure to create separation between deputies and the subject, allowing for reassessment and consideration of alternative force options."*

Excited delirium

The current policy includes language regarding ECW probe removal, specifying that only trained medical professionals may perform removal under certain circumstances. One such circumstance is when "the subject is displaying signs of excited delirium."

Given that the term “excited delirium” has become politicized and lacks consistent clinical recognition, PERF recommends replacing it with a more appropriate, neutral term such as “medical-behavioral emergency (MBE).” This terminology better reflects the nature of the condition and aligns with evolving best practices in both law enforcement and medical response.

Recommendation 31. *VBSO should replace all references to “excited delirium” in its policies with “medical-behavioral emergency (MBE)” to ensure clarity, neutrality, and alignment with current professional standards.*

General Order 08-13-00 Arrest/Detention and Handling of Juveniles

This policy is broadly consistent with the Code of Virginia’s requirements governing juvenile custody, detention, and interrogation. The Code is referenced throughout the policy, and many required statutory procedures are properly embedded. To further reinforce compliance and ensure deputies apply the statute consistently in the field, PERF recommends adding the following sentence to the Policy Statement:

“Virginia Beach Sheriff’s Office deputies shall at all times adhere to the provisions of Code of Virginia §16.1-247 and ensure that all procedures related to juvenile custody—including decisions regarding release, recognizance, or transport to intake, shelter, or detention—are carried out in accordance with the operating hours of the juvenile court and as otherwise required by law.”

Including this statement prominently in the Policy Statement not only reinforces statutory compliance but also ensures that future revisions to the policy remain aligned with any amendments to §16.1-247 or related juvenile justice statutes.

Recommendation 32. *VBSO should add a sentence to the Policy Statement of General Order 08-13-00 Arrest/Detention and Handling of Juveniles affirming that its deputies shall adhere at all times to Code of Virginia §16.1-247.*

General Order 10-06-00 Felony Screening Procedure

This policy complies with standard Commonwealth’s Attorneys procedures across Virginia and aligns with the accepted statewide model for felony case review. The Policy Statement could be modified to reduce wordiness while better capturing its spirit.

Currently, the Policy Statement reads:

“In order to ensure that effective case preparation is accomplished at both the enforcement and prosecutorial levels, it is necessary to establish a set of uniform procedures whereby felony cases are screened by the Office of the Commonwealth’s Attorney prior to prosecution. These procedures are in no way designed to minimize the discretionary or decision-making capabilities of deputies; in fact, the procedures are intended to maximize

the active involvement of the deputy in the prosecution of the case. Deputies are advised that the duty attorney will be available by telephone to provide legal advice whenever necessary.”

PERF recommends modifying the statement to read:

“These procedures will ensure consistent, uniform handling of felony matters and promote effective case preparation at both the enforcement and prosecutorial levels. All felony cases shall be screened with the Office of the Commonwealth’s Attorney in accordance with established timelines. Deputies will provide complete case documentation and actively participate in charging decisions, follow-up investigations, and victim consultation in accordance with Virginia’s best practices. The duty attorney remains available by telephone to provide legal guidance whenever needed.”

Recommendation 33. *VBSO should consider modifying the Policy Statement of General Order 10-06-00 Felony Screening Procedure. The current language is wordy while also missing some key points that would better capture the purpose of the policy. It could be modified to the language PERF has proposed.*

General Order 11-05-00 Use of Restraint Equipment

This policy exceeds the minimum requirements of Virginia’s Administrative Code, 6VAC15-40-980 (Restraint equipment). That regulation contains two mandates:

1. A written policy, procedure, and practice governing the use of restraint equipment
2. A written protocol for monitoring inmates in restraint equipment, which must be approved by the medical authority³⁷

The existing VBSO policy already provides comprehensive procedures and detailed operational guidance. To further strengthen clarity and audit readiness, an additional sentence should be placed at the beginning of the procedures section explicitly stating that all monitoring protocols outlined in this policy are approved by the facility’s medical authority and reviewed annually. This addition would remove any ambiguity during compliance reviews and clearly demonstrate compliance with the “approved by the medical authority” requirement of 6VAC15-40-980.

Recommendation 34. *VBSO should update the Procedures portion of General Order 11-05-00 (Use of Restraint Equipment) to include the explicit statement, “all monitoring protocols outlined in this policy are approved by the facility’s medical authority and reviewed annually.”*

37. 6 VA. ADMIN. CODE 15-40-980 Restraint Equipment (2012), <https://law.lis.virginia.gov/admincode/title6/agency15/chapter40/section980/>.

General Order 13-01-00 Intake and Intake Classification Process

The VBSO Policy and Procedure on the Intake and Classification Process complies with Virginia correctional standards, but PERF noted one area for slight improvement.

The “Classification Process during Intake” section comports with 6VAC15-40-830 (Inmate handbook)³⁸ by describing how inmates receive the Rules & Regulations booklet, which contains the facility’s conduct rules and policies governing inmate discipline including sanctions. This booklet satisfies the regulation’s requirement that inmates be provided with written rules and information on disciplinary procedures.

However, the policy does not explicitly address the regulation’s requirement that inmates sign for receipt of the handbook, even though the process of providing and explaining the rules is clearly established.

Recommendation 35. *VBSO should add the following language to General Order 13-01-00 Intake and Intake Classification Process: “Inmates shall sign a receipt acknowledging that they have been issued the Rules & Regulations for the Virginia Beach Correctional Center booklet in accordance with 6VAC15-40-830.”*

38. 6 VA. ADMIN. CODE 15-40-830 Inmate Handbook (2012),
<https://law.lis.virginia.gov/admincode/title6/agency15/chapter40/section830/>.

Training

Use of Force

As noted in the [Interviews and Observations](#) section beginning on page 2, during a site visit in July, the PERF team observed VBSO training sessions at the academy including both recruit and in-service programs. The team was impressed by the high level of engagement from cadets and current staff. Instruction was comprehensive and grounded in realistic, scenario-based exercises that reflect the complexities of modern jail and patrol operations.

Training modules included instruction on restraint-related deaths (referred to by VBSO as “positional asphyxia”), a hands-on exercise using the WRAP restraint device (demonstrating how to safely secure a combative subject), and a simulation requiring staff to de-escalate an individual with a mental illness who was shouting in public. These sessions were thoughtfully designed to challenge participants and foster meaningful engagement with complex subject matter in a controlled, supportive environment.

In August 2025, five VBSO sergeants took a significant step forward by attending PERF’s ICAT train-the-trainer course in Decatur, Illinois, funded by the U.S. Department of Justice’s Office of Community Oriented Policing Services.³⁹ ICAT—Integrating Communications, Assessment, and Tactics—is PERF’s evidence-based UOF training program designed to help officers defuse critical incidents using techniques that emphasize time, distance, and cover.⁴⁰ Independent research has shown that ICAT implementation significantly reduces UOF incidents and injuries to both civilians and officers.⁴¹

PERF has also published *ICAT for Jails: A Guide for Minimizing Use of Force in Correctional Facilities*, which is particularly relevant to VBSO.⁴² Notably, ICAT includes a dedicated module on reducing the risk of restraint-related death, incorporating principles from PERF’s *15 Principles for Reducing the Risk of Restraint-Related Death*.⁴³ Implementing these practices would demonstrate VBSO’s commitment to preventing future tragedies and upholding the sanctity of life.

39. Funding for VBSO to send sergeants to Decatur was provided under COPS Office grant 15JCOPS-24-GK-04174-DETX.

40. PERF, *ICAT: Integrating Communications, Assessment, and Tactics. A Training Guide for Defusing Critical Incidents* (Washington, DC: Police Executive Research Forum, 2016), <http://www.policeforum.org/assets/icattrainingguide.pdf>.

41. Robin S. Engel et al., *Examining the Impact of Integrating Communications, Assessment, and Tactics (ICAT) De-escalation Training for the Louisville Metro Police Department: Initial Findings* (Cincinnati, OH: University of Cincinnati Center for Police Research and Policy, 2022), <https://www.policinginstitute.org/publication/examining-the-impact-of-integrating-communications-assessment-and-tactics-icat-de-escalation-training-for-the-louisville-metro-police-department-report-2-supplemental-findings/>.

42. PERF, *ICAT for Jails: A Guide for Minimizing Use of Force in Correctional Facilities* (Washington, DC: Police Executive Research Forum, 2016), <https://www.policeforum.org/assets/ICATJails.pdf>.

43. PERF, *15 Principles* (see note 27).

The VBSO sergeants who attended the ICAT training were highly engaged and motivated. While their participation reflects a strong commitment to continuous improvement, the true impact will come only with effective agency-wide implementation. VBSO should prioritize integrating ICAT across all levels to ensure its benefits are fully realized.

Recommendation 36. *VBSO should implement ICAT agency-wide. The program, which has been independently evaluated and shown to lead to significant reductions in UOF, includes a module on mitigating the risk of restraint-related death. Adopting ICAT would reinforce VBSO's commitment to the sanctity of life and ongoing professional development.*

The core element of ICAT is the Critical Decision-Making Model (CDM) [ICAT Module 2]. The CDM provides a clear, intuitive framework that helps officers structure and guide their decision-making. It consists of five steps that can be applied to any incident, particularly UOF encounters:

1. Gather information.
2. Assess the situation, threats, and risks.
3. Consider police powers and agency policy.
4. Identify options and determine the best course of action.
5. Act, review, and re-assess.

The CDM is designed as a circular—not linear—model, encouraging officers to continually revisit earlier steps as circumstances change. To reinforce this dynamic decision-making process, some agencies display the CDM on cards, posters, or other visual reminders. For example, figure 25 on page 57 shows a poster featuring the Harris County (TX) Sheriff's Office's CDM.

Figure 25. Harris County Sheriff's Office Critical Decision-Making Model



Internalizing the CDM would benefit members of the VBSO by helping them develop an automatic, disciplined thought process—promoting ongoing reassessment and reducing the likelihood of decisions driven by tunnel vision.

Report writing

As noted in the **Lack of Automated Reporting System / Written Reports** section beginning on page 7), the reports PERF reviewed during the audit revealed several deficiencies. Many lacked the critical detail expected in an RTR report, while others were poorly written or incomplete. These issues both affect the accuracy of incident documentation and hinder supervisors' ability to evaluate deputy performance.

While automation and reducing redundant reporting requirements will help improve report quality, these measures alone will not fully address the underlying issues. To elevate the overall standard of written reports, VBSO should consider training deputies to apply the CDM as a structured framework for drafting RTR reports. Using the CDM to guide report writing reinforces sound decision-making principles and serves as a practical reminder of the key elements that should be documented in every UOF report.

The North Richland Hills (TX) Police Department provides a strong example. The department not only trains officers to use the CDM when writing UOF reports but also formally embeds that expectation in policy:

"303.15 General Reporting Procedures

- A. An employee exercising force in the performance of their official duties shall notify the on-duty supervisor of the use of force and articulate the details regarding the use-of-force in an offense report, or if not applicable, an information report.
- B. Utilizing the CDM as a platform to document one's observations and actions in full, the report should detail the totality of the circumstances, including such details as:
 - 1. The nature of the incident which first brought the employee in contact with the subject;
 - 2. The subject's demeanor and attitude;
 - 3. The number of subjects involved in the incident;
 - 4. The environmental factors surrounding the incident;
 - 5. Type of resistance or force used or threatened by the subject;
 - 6. Reason for the use of force by the employee;
 - 7. Type of force used by the employee;
 - 8. Details of actions and statements made by the subject and employee both before and after the incident;
 - 9. Detailed descriptions, including photographs when possible, of injuries sustained by any person; and
 - 10. Description of any medical aid given to any injured person."⁴⁴

Recommendation 37. *VBSO should train its deputies to use the CDM when completing RTR reports. Doing so would create a consistent, structured approach to report writing; improve the clarity, completeness, and defensibility of deputies' accounts; reinforce the habit of ongoing assessment and articulation of decision-making; and ultimately strengthen both internal review processes and public trust.*

The WRAP

The incident that prompted this review began when Rolin Hill was brought to the VBCC by another agency, arriving in the WRAP restraint device.

44. "Response to Resistance and Aggression," *General Order 303.00* (North Richland Hills, TX: North Richland Hills Police Department, 2025), <https://public.powerdms.com/NRHPD/tree/documents/628202>.

The WRAP is specifically designed to restrain agitated or combative individuals (whatever the cause of their agitation) without compromising their ability to breathe. It prevents subjects from kicking or striking officers while allowing them to calm down in a secure manner that does not obstruct breathing, reducing the likelihood of injury to themselves or others.

Although VBSO personnel removed the device, our review—limited to publicly released video—suggests that Mr. Hill’s death was not solely attributable to the physical act of removing the WRAP. Nonetheless, following the incident, VBSO issued a directive requiring any agency transporting an individual in the WRAP to have their own personnel remove the device before they leave the VBCC facility. Although this was an understandable immediate response—intended to ensure VBSO deputies were not responsible for removing the WRAP—the policy assumes that every person arriving at the VBCC in the WRAP is ready to be safely removed from it simply because the transporting agency is ready to leave.

We therefore recommend that VBSO reconsider this practice. Restoring the previous procedure, in which trained VBSO personnel remove the WRAP, would support safer, more controlled transitions and help minimize the risk of escalation. This recommendation is consistent with broader training-focused reforms, including those outlined in recommendation 36 on page 56.

During interviews, many VBSO personnel expressed concern that the current WRAP policy places deputies in even more difficult, potentially unsafe situations. Individuals arriving at the VBCC in the WRAP are often agitated or combative (which is why they have been placed in the WRAP in the first place), and requiring personnel from the transporting agency to remove it simply because they are ready to leave—irrespective of whether it makes sense to do so—can create unnecessary risk. VBSO deputies are frequently left in the precarious position of having to physically engage with individuals who might have de-escalated had they remained in the restraint device a bit longer. Revisiting this policy and ensuring that all VBSO personnel are trained in the safe removal and management of individuals in the WRAP might better support officer safety while reducing the likelihood of unnecessary force.

Recommendation 38. *VBSO should consider reverting to its previous policy, allowing trained VBSO personnel to remove the WRAP, rather than requiring the transporting agency to do so. In addition, VBSO should ensure all staff are trained in the safe removal and management of individuals in the WRAP to promote safety, reduce unnecessary force, and support de-escalation.*

Lateral restraint techniques

During our site visit and observation of VBSO training, we learned that an increasing number of trainers and deputies are studying and applying elements of Brazilian jiu-jitsu to improve safety for both officers and subjects when physical control becomes necessary. VBSO is not unique in this regard;⁴⁵ agencies nationwide are turning to grappling-based approaches to reduce injuries and improve control outcomes.

One technique that may be of particular interest is the SafeWrap method, which enables officers to restrain a subject—including applying handcuffs—without ever placing the individual in a prone position.⁴⁶ Although at the time of this writing, SafeWrap has not yet been the subject of formal, peer-reviewed research validating its safety, the potential benefits justify monitoring its development. As outlined in our *15 Principles* publication,⁴⁷ prone restraint can present increased risks for certain individuals, and exploring techniques that allow deputies to safely secure a person without resorting to face-down positioning is a forward-leaning practice that VBSO should continue to watch closely.

Roll-call (Muster)

At each shift change, the VBSO conducts its roll-call process, referred to as *Muster*. During this briefing, supervisors provide the oncoming shift with updates on operational issues, emerging concerns, and other relevant information.

During PERF's site visit, we observed that VBSO employs well-regarded mental health professionals in the facility. The rapport, collaboration, and mutual respect among sworn staff and the mental health team were evident. However, these professionals currently do not have a formal mechanism for engaging more broadly with staff on a routine basis to share observations, discuss emerging behavioral patterns, or reinforce de-escalation techniques.

To strengthen this valuable partnership, VBSO should consider implementing a regular schedule—monthly or every other month—in which a member of the mental health team participates in *Muster*. This routine visit would provide a short, structured training opportunity focused on topics relevant to deputies. It would also create space for deputies to raise questions, seek guidance, and share their own observations, reinforcing a proactive approach to behavioral health and de-escalation across the facility.

45. Katja Ridderbusch, "Cops Are Turning to Jiu-jitsu to Curb Harmful Force, Boost Mental and Physical Health," *U.S. News & World Report*, March 29, 2022, <https://www.usnews.com/news/health-news/articles/2022-03-29/police-turn-to-jiujitsu-to-curb-dangerous-force-boost-mental-and-physical-health>.

46. Jonathan Alsup, "Is Rener Gracie's 'Safewrap' Technique a Game Changer for Law Enforcement Restraint Methods?" *Police1*, last modified August 8, 2024, <https://www.police1.com/police-training/is-rener-gracies-safewrap-technique-a-game-changer-for-law-enforcement-restraint-methods/>.

47. PERF, *15 Principles* (see note 27).

Recommendation 39. *VBSO should establish a recurring schedule—such as monthly or every other month—for mental health staff to participate in Muster. Incorporating mental health professionals into these briefings would enable them to share observations, trends, and practical de-escalation strategies with deputies, while also creating a regular forum for staff to ask questions and exchange insights. This structured engagement would strengthen collaboration, enhance deputies’ preparedness, and reinforce a proactive approach to behavioral health–informed practices across the facility.*

Early Intervention System

The Early Intervention System (EIS) has become a common and widely adopted tool in modern police personnel management.⁴⁸ The core premise behind an EIS is that serious incidents of police misconduct rarely occur without warning. Instead, such events are often preceded by a series of minor incidents or emerging patterns of behavior. An EIS is designed to help agencies identify these early indicators so they can be addressed proactively—through training, counseling, or other nonpunitive measures—before they escalate into more serious forms of misconduct.⁴⁹

Though EISs are adaptable to each agency, an effective EIS must include the following:

- **A flagging mechanism.** The agency must identify officers whose patterns of behavior, measured against agency-defined thresholds, may indicate an area of concern and trigger a review.
- **Time parameters.** The agency must determine the time within which the flagging mechanism signals an issue.
- **Evaluation of situational factors.** After the flag or trigger, a supervisor or a team reviews the situational factors to determine whether remediation is necessary and if so, what type.
- **Documentation of supervisory or command review.** The EIS should contain a mechanism for a supervisor to review a flagged alert and capture any remedial action so the agency can track interventions, monitor progress, and support performance management.⁵⁰

48. Robert E. Worden et al., *Police Early Intervention Systems: The State of the Art* Document No. 310787 (Albany, NY: John F. Finn Institute for Public Safety, 2018), <https://www.ojp.gov/library/publications/police-early-intervention-systems-state-art>.

49. Karen L. Amendola and Robert C. Davis, *Best Practices in Early Intervention System Implementation and Use in Law Enforcement Agencies* (Arlington, VA: National Policing Institute, 2019), <https://www.policinginstitute.org/publication/best-practices-in-early-intervention-system-implementation-and-use-in-law-enforcement-agencies/>.

50. Amendola and Davis, *Best Practices in Early Intervention* (see note 49).

An effective EIS will track and monitor far more than UOF incidents. Agencies rely on EIS platforms to identify patterns involving officer complaints, abuse of sick leave, tardiness, civil actions filed against officers, domestic violence investigations, positive drug tests, insubordination, neglect of duty, and numerous other behaviors that may signal emerging concerns.

As noted in the **Deputy Involvement** (in RTRs) section beginning on page 35, the VBSO cannot currently implement an effective EIS because its internal systems are not automated. For an agency of its size and level of modernization, this represents an exception rather than the norm.

Based on everything we observed at the VBSO, it is an extremely professional agency, and the incident prompting this review appears to be a genuine anomaly. However, had any involved personnel exhibited escalating behavior, the absence of an EIS meant there was no structured way to detect and address such issues before they culminated in such a tragic outcome.

In addition, as noted in figure 21 on page 35, in 2024, some deputies used force at disproportionately higher rates than others, with one deputy demonstrating an exceptionally elevated level. An effective EIS could have identified and flagged these patterns for timely review and intervention.

We strongly recommend that the VBSO explore adopting an EIS capable of evaluating a wide range of performance and risk indicators. PERF does not endorse specific vendors, but VBSO should ensure that whatever platform it selects, offers the breadth of analytical and monitoring capabilities that could substantially benefit the agency.

Recommendation 40. *VBSO should adopt an automated Early Intervention System (EIS) to identify and address emerging performance or behavioral concerns before they escalate. Such a system would allow supervisors to track key indicators, review flagged patterns promptly, and implement timely, nonpunitive interventions. Implementing an EIS would modernize VBSO's personnel management practices and help ensure the early detection of issues that might otherwise go unaddressed.*

Conclusion

The VBSO initiated this review in the wake of an in-custody death that understandably prompted deep reflection and a commitment to reassessing policies, practices, and organizational culture. PERF's comprehensive analysis found that, although the incident that spurred this review was extraordinarily serious, VBSO otherwise demonstrates professionalism, a strong training culture, and a genuine dedication to the dignity and safety of those in its care—providing a solid foundation on which to build further improvements. Deputies and supervisors consistently expressed pride in their work and a clear willingness to adopt reforms that strengthen safety, accountability, and public confidence.

At the same time, our review identified several systemic issues—most notably an overly expansive definition of Response to Resistance, a burdensome manual reporting process, and the absence of automated data systems—that hinder VBSO's ability to understand patterns, deploy resources effectively, and communicate transparently. The analysis of 2024 RTR incidents showed that current practices capture large volumes of low-level encounters, which in turn makes it difficult to surface meaningful trends such as demographic disparities, repeat-involved subjects and deputies, and operational drivers of RTR peaks. In other words, excessive data collection without adequate structure can obscure the very information needed to detect emerging issues or monitor risk. Addressing these issues is not simply an administrative upgrade; it is central to strengthening decision-making, enhancing oversight, and better supporting deputies.

PERF also found considerable strengths in VBSO's existing policies—such as robust de-escalation language, the duty to intervene, strong restrictions on deadly force, and requirements for continuous monitoring during restraint—while offering targeted recommendations to further align VBSO with contemporary best practices. Opportunities exist to modernize force-related policies, consolidate them into a more user-friendly structure, clarify key definitions, and ensure that high-risk incidents receive consistent and rigorous review. Likewise, investments in evidence-based training, including agency-wide implementation of ICAT, adopting the CDM as an agency-wide philosophy, and continued emphasis on scenario-based instruction, will help deputies safely resolve complex situations involving individuals with mental illnesses, substance use disorders, or heightened emotional distress.

Finally, the implementation of an automated reporting system—followed by the adoption of an Early Intervention System and enhanced transparency measures—will position VBSO to become a national model for correctional accountability. These tools will allow the agency to track important indicators, identify emerging concerns early, and communicate more clearly with the public about how force is used and reviewed. Taken together, the findings and recommenda-

tions in this report support a forward-looking vision in which VBSO continues to evolve as a modern, data-informed, learning oriented agency committed to safety, fairness, and the sanctity of human life.

In sum, while the impetus for this review was tragic, the opportunity it creates is meaningful. By embracing the reforms outlined throughout this report, VBSO can strengthen its internal systems, reinforce community trust, and build on its existing strengths to ensure that its policies, practices, and training reflect the highest standards of contemporary correctional care.

Appendix. Recommendations

Recommendation 1. The VBSO should revise its definition of Response to Resistance, the criteria for what constitutes a Reportable Response to Resistance, or both. The current definition and reporting requirements are overly expansive, thereby consuming disproportionate staff time and resources. Streamlining these criteria would enable the agency to focus its efforts on incidents warranting closer scrutiny, enhance the clarity and utility of its data, and better align its practices with contemporary law enforcement reporting standards.

Examples of language that would narrow the definition of reportable RTRs while still ensuring the documentation of actual uses of force can be found in the policies of the Seattle, Baltimore, and Virginia Beach Police Departments, as well as the Harris County (TX) and St. Mary's County (MD) Sheriffs' Offices. Adopting a similar threshold would allow VBSO to maintain appropriate oversight of force incidents without over-capturing routine, low- impact encounters.

Recommendation 2. The VBSO must urgently prioritize implementing an automated system to report and document Responses to Resistance. The current process is outdated, inefficient, and duplicative, and it does not support the level of data analysis required to drive meaningful change. Modernizing this system will improve data accuracy, reduce administrative burden, and enable more effective oversight.

Recommendation 3. VBSO should strategically evaluate the types of data it collects to ensure they are meaningful, actionable, and aligned with the agency's operational and oversight goals. The system should be designed with flexibility to evolve, allowing VBSO to incorporate new data fields as needs and priorities shift.

Recommendation 4. VBSO should evaluate whether its current staffing is sufficient to account for the disproportionate increase in RTRs during the 8:00–9:00 a.m. hour and adjust accordingly. There may be a need for shift adjustments.

Recommendation 5. VBSO should ensure staff are fully aware that the 8:00–9:00 a.m. hour represents a disproportionate risk for RTR incidents. Training programs should explicitly incorporate this risk into scenario-based exercises, emphasizing strategies for proactive engagement, heightened situational awareness, and effective de-escalation techniques during this critical period.

Recommendation 6. VBSO should begin collecting data on individuals who identify as Hispanic or Latino. Including this category will improve the quality and completeness of RTR data and help ensure that all demographic groups are appropriately represented in future analyses.

Recommendation 7. VBSO should prioritize tracking and evaluating RTRs involving women. Although White women represent a higher average percentage of the VBCC population, Black women are involved in RTRs at a disproportionately higher rate.

Recommendation 8. VBSO should develop scenario-based training programs that align with the RTR patterns most frequently encountered in the VBCC. Priority should be given to frequent scenarios involving men ages 20–29, as this demographic accounts for nearly half of all RTRs.

Recommendation 9. VBSO should establish a process to flag and classify repeat RTR subjects and the nature of prior incidents so that upon their arrival at the VBCC, de-escalation efforts can be planned and tailored to the individual.

Recommendation 10. VBSO should work with its medical and mental health practitioners to develop a more nuanced intake process for individuals who refuse to answer all intake questions. Automatically placing every such person on suicide watch is inefficient and may divert resources from inmates who are at genuine risk. A tiered observation system—tailored to how the individual is presenting—would likely function more effectively, but these determinations should be made in coordination with local medical and mental health professionals.

Recommendation 11. VBSO should ensure that, once automated, it tracks deputy injuries in a way that more accurately captures whether those engaged in RTRs are physically harmed. The current method does not allow for meaningful analysis and likely undercounts deputy injuries.

Recommendation 12. After implementing an automated data-capture system and ensuring accurate, contextually relevant RTR data, VBSO should consider publishing this information on its website through a publicly accessible use of force portal.

Recommendation 13. The VBSO should make its policies and general orders publicly accessible online. This action would demonstrate the agency’s commitment to transparency and help build trust with the community it serves.

Recommendation 14. VBSO should consider consolidating all force-related policies into a single, comprehensive document organized by clearly defined sections.

Recommendation 15. After implementing PERF’s UOF policy recommendations, VBSO should present the revised policies to sergeants first and then to deputies with an overview training session. Moving forward, training on all aspects of force should reflect the new policies. Where possible, this training should include a scenario-based component that allows deputies to apply their training to real-life situations.

Recommendation 16. VBSO should incorporate a clear and prominent policy statement at the beginning of its UOF policy affirming the sanctity of human life. This statement should set the tone for the entire policy and reflect the agency’s commitment to respectful, accountable, and community-centered policing.

Recommendation 17. VBSO should incorporate language into its UOF policy statement that highlights de-escalation as a core element of its overall approach. The statement should make clear that de-escalation not only is encouraged but also is often the most effective and appropriate response in high-stress situations.

Recommendation 18. VBSO should incorporate language into its UOF policy statement that affirms proportionality as a guiding principle. The statement should emphasize that officers are expected to use only the level of force necessary to respond to a given threat and to continually reassess the situation to ensure their response remains appropriate and justified.

Recommendation 19. VBSO should include a formal definition of de-escalation in the Definitions section of General Order 11-01-00.

Recommendation 20. VBSO should include a formal definition of proportionality in the definitions section of its UOF policy.

Recommendation 21. VBSO should revise the RTR policy to require that “after any response to resistance, deputies must offer medical assistance to the subject.”

Recommendation 22. VBSO should remove the limited language on less-lethal weapons currently found in GO 11-01-00 (section 4) and incorporate the full content of GO 11-02-00 into a revised, comprehensive UOF policy.

Recommendation 23. VBSO should consider modifying General Order 11-01-00(11) to remove the blanket requirement that every involved deputy must document every use of force. Instead, documentation could be required for the following:

- Force exceeding basic push or pull methods used to escort or direct a subject exhibiting no or little resistance
- The pointing of an ECW at an individual as a threat of force
- The use of a lethal weapon, a less-lethal weapon, or a weapon of opportunity
- Any instance where injury is observed or alleged by the person who was subject to an officer’s UOF
- Any incident where the supervisor, at their discretion, directs it

Recommendation 24. VBSO should modify General Order 11-01-00(12)(B) to require that the sheriff or their designee convene a board of inquiry after every serious use of force.

Recommendation 25. If VBSO maintains separate policies related to UOF, it should incorporate the policy statement from General Order 11-01-00 into the weapons policy. This statement should explicitly include the concepts of sanctity of life, de-escalation, and proportionality.

Recommendation 26. If VBSO elects to retain separate UOF policies, it should integrate the definitions section from General Order 11-01-00 into the weapons policy. This section should explicitly include definitions of de-escalation and proportionality to ensure alignment with best practices and the agency’s philosophy.

Recommendation 27. VBSO should replace all references to “Taser Energy Weapons” and “TEW” with the widely accepted generic term “electronic control weapon” or ECW.

Recommendation 28. VBSO should modify its policy language and practice to require that, whenever feasible, a deputy give a verbal warning both to the subject and to other nearby deputies before deploying an ECW.

Recommendation 29. VBSO should add language to its policy stating, “Personnel shall not intentionally activate more than one ECW at a time against a subject.”

Recommendation 30. VBSO should revise the Drive Stun section to state, “Drive Stun mode shall be used only to supplement probe mode to complete the incapacitation circuit or as a countermeasure to create separation between deputies and the subject, allowing for reassessment and consideration of alternative force options.”

Recommendation 31. VBSO should replace all references to “excited delirium” in its policies with “medical-behavioral emergency (MBE)” to ensure clarity, neutrality, and alignment with current professional standards.

Recommendation 32. VBSO should add a sentence to the Policy Statement of General Order 08-13-00 Arrest/Detention and Handling of Juveniles affirming that its deputies shall adhere at all times to Code of Virginia §16.1-247.

Recommendation 33. VBSO should consider modifying the Policy Statement of General Order 10-06-00 Felony Screening Procedure. The current language is wordy while also missing some key points that would better capture the purpose of the policy. It could be modified to the language PERF has proposed.

Recommendation 34. VBSO should update the Procedures portion of General Order 11-05-00 (Use of Restraint Equipment) to include the explicit statement, “all monitoring protocols outlined in this policy are approved by the facility’s medical authority and reviewed annually.”

Recommendation 35. VBSO should add the following language to General Order 13-01-00 Intake and Intake Classification Process: “Inmates shall sign a receipt acknowledging that they have been issued the Rules & Regulations for the Virginia Beach Correctional Center booklet in accordance with 6VAC15-40-830.”

Recommendation 36. VBSO should implement ICAT agency-wide. The program, which has been independently evaluated and shown to lead to significant reductions in UOF, includes a module on mitigating the risk of restraint-related death. Adopting ICAT would reinforce VBSO’s commitment to the sanctity of life and ongoing professional development.

Recommendation 37. VBSO should train its deputies to use the CDM when completing RTR reports. Doing so would create a consistent, structured approach to report writing; improve the clarity, completeness, and defensibility of deputies’ accounts; reinforce the habit of ongoing assessment and articulation of decision-making; and ultimately strengthen both internal review processes and public trust.

Recommendation 38. VBSO should consider reverting to its previous policy, allowing trained VBSO personnel to remove the WRAP, rather than requiring the transporting agency to do so. In addition, VBSO should ensure all staff are trained in the safe removal and management of individuals in the WRAP to promote safety, reduce unnecessary force, and support de-escalation.

Recommendation 39. VBSO should establish a recurring schedule—such as monthly or every other month—for mental health staff to participate in Muster. Incorporating mental health professionals into these briefings would enable them to share observations, trends, and practical de-escalation strategies with deputies, while also creating a regular forum for staff to ask questions and exchange insights. This structured engagement would strengthen collaboration, enhance deputies' preparedness, and reinforce a proactive approach to behavioral health-informed practices across the facility.

Recommendation 40. VBSO should adopt an automated Early Intervention System (EIS) to identify and address emerging performance or behavioral concerns before they escalate. Such a system would allow supervisors to track key indicators, review flagged patterns promptly, and implement timely, nonpunitive interventions. Implementing an EIS would modernize VBSO's personnel management practices and help ensure the early detection of issues that might otherwise go unaddressed.



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