

**Office of Internal Oversight Review**  
**Key Findings, Conclusions, and/or Recommendations of an Officer-Involved Shooting: Fatal**  
**7403 Newcrest Circle – November 6, 2017**

**Purpose**

The purpose of this report is to publish key findings, conclusions, and/or recommendations of the Las Vegas Metropolitan Police Department's (LVMPD) internal review of this incident. There are a variety of actions that can be taken administratively in response to the Department's review of a deadly force incident. The review may reveal no action is required or determine additional training is appropriate for all officers in the workforce, or only for the involved officer(s). The review may reveal the need for changes in Department policies, procedures, or rules. Where Departmental rules have been violated, formal discipline may be appropriate. The goal of the review is to improve both individual and Department performance.

**Synopsis of Event**

On November 6, 2017, at approximately 0218 hours, the Las Vegas Metropolitan Police Department (LVMPD) was involved in a critical incident under LVMPD Event LLV171106003988. The incident occurred near 7403 Newcrest Circle, Las Vegas, Nevada 89147. This address was located within the LVMPD Enterprise Area Command (EAC); sector beat Sam 2 (S2).

The incident was an officer-involved shooting (OIS). Special Weapons and Tactics (SWAT) Officers Levi Hancock and Kai Hoskins were the involved officers who discharged their firearms at suspect Jarrett Varnado, who was armed with a handgun. Varnado was struck multiple times and later pronounced deceased.

Prior to the OIS, LVMPD Communications received two 9-1-1 calls from citizens reporting they observed a dead body in front of a residence on the 7300 block of Newcrest Circle. The citizens also advised the body was not the homeowner and they were concerned for the homeowner's welfare due to a trail of blood leading into the residence. Patrol officers arrived and conducted a welfare check of residence. During the welfare check, officers located a second dead body inside the residence, later determined to be the homeowner.

Officers canvassed the neighborhood. Witnesses advised Varnado, who also resided on Newcrest Circle, had threatened to kill the victim a week prior. As officers were interviewing witnesses, Varnado's family arrived and confirmed he lived at 7403 Newcrest Circle. Varnado's mother told detectives he suffered from a mental disorder and was known to carry a small framed handgun in a shoulder holster. The family also advised they believed Varnado was the only person inside of the residence. A records check of the residence showed a hazard notification was placed on the residence for prior altercations with officers.

Officers made several attempts to call Varnado over the Public Address System (PA). Varnado did not respond and there was no indication he was inside the residence. Supervisors formulated a Force Protection Team for detectives and crime scene analysts (CSA) to process the scene. A SWAT Lieutenant was notified with details of the call, including that Varnado was suspected to be inside the residence next to the crime scene. At 1843 hours, SWAT officers arrived with BearCat armored vehicles, as homicide detectives and CSA's processed the original crime scene.

Homicide spoke with Varnado's family. There was not a basis to keep the family from entering the residence. When the family opened the garage, they observed a silver Chevrolet sedan inside that did not belong to Varnado. Detectives determined the vehicle belonged to one of the victims. The vehicle was cold plated with a license plate belonging to Varnado. Based upon gathered information, a search warrant was obtained for Varnado's residence.

**Office of Internal Oversight Review**  
**Key Findings, Conclusions, and/or Recommendations of an Officer-Involved Shooting: Fatal**  
**7403 Newcrest Circle – November 6, 2017**

At approximately 2315 hours, SWAT officers were briefed by homicide detectives that Varnado was a possible suspect in a double homicide, potentially armed with a firearm, and could potentially be located in his bedroom which overlooked the front of the residence. SWAT officers formulated a tactical plan to include assigning specific roles and responsibilities. SWAT Officer Hoskins was assigned as the shield officer for the entry team and SWAT Officer Hancock was assigned as the breach team leader.

At 0024 hours, SWAT officers set up containment of the residence. The Air Unit conducted a flyover and shined their light through Varnado's bedroom window to make him aware of the police presence. Simultaneously, verbal commands for Varnado to exit were made for approximately 12 minutes with no response. During this time, two distract devices were deployed on the residence.

At 0039 hours, SWAT and K9 cleared the garage of Varnado's residence. An explosive breach was used on a front window to allow entry of a robot to clear the bottom floor. SWAT officers held at the front door as the robot was directed to the second floor to clear the upstairs area. The robot got stuck in a second-floor bathroom; therefore, a K9 dog was deployed up the stairs. The K9 dog did not alert to anything upstairs. SWAT officers proceeded upstairs to clear the second floor except for Varnado's bedroom, whose door was closed. SWAT officers regrouped and prepared to clear the bedroom.

An explosive breach was used to gain access into Varnado's bedroom and verbal commands were issued. When no response was achieved, the K9 dog was sent into the room. When SWAT officers approached the room, Officer Hoskins observed Varnado lying on top of the K9 dog. As additional SWAT officers entered the room, Officer Hancock went hands on with the suspect as a K9 Sergeant retrieved his dog.

While SWAT officers were in Varnado's room, he pointed a firearm at SWAT officers. SWAT Officer Hoskins fired one round. Simultaneously, SWAT Officer Hancock discharged his firearm.

After Varnado was taken into custody, he was brought to LVMPD Tactical Medics on scene for medical intervention. Varnado was transported by ambulance to University Medical Center (UMC) where he was pronounced deceased.

### **The Criminal Investigation**

LVMPD Force Investigation Team (FIT) conducted the criminal investigation of this incident. Their investigation was submitted to the District Attorney's Office for review. The District Attorney's Office determined that, "no criminal prosecution of the officer or officers involved in the referenced case is appropriate."

For additional information related to the investigation of this incident, please refer to LVMPD's FIT Report, the Clark County District Attorney's Legal Analysis Report, and/or the Clark County District Attorney's Decision document.

### **LVMPD Administrative Review and Critical Incident Review Process**

It is the policy of this Department to provide both the LVMPD and the community with a thorough review of incidents wherein deadly force was used by Department members. The Critical Incident Review Process (CIRP), includes the participation of citizen board members who reside within the LVMPD jurisdiction, who

**Office of Internal Oversight Review**  
**Key Findings, Conclusions, and/or Recommendations of an Officer-Involved Shooting: Fatal**  
**7403 Newcrest Circle – November 6, 2017**

are not personally affiliated with the Department, who are not related to any of its members, and who have not had prior law enforcement experience.

The CIRP is comprised of two (2) related boards whose sole purpose is to conduct comprehensive administrative review of the tactics utilized by involved Department members as well as decision-making, Department policy, training, supervision, and the use of deadly force.

The Use of Force Review Board (UFRB) consists of both commissioned and citizen members. The Critical Incident Review Team (CIRT) presents the facts related to the use of deadly force. The board issues findings regarding the actions of Department members who used, directly ordered, or directly influenced the use of deadly force, whether such force resulted in death or serious injury. The UFRB may choose from one (1) of four (4) findings after hearing the presentation of facts from CIRT. The findings are Administrative Approval, Tactics/Decision-Making, Policy/Training Failure or Administrative Disapproval.

The Tactical Review Board (TRB) reviews CIRT conclusions. The TRB can validate, overturn, or modify the conclusions regarding the actions of Department members.

The matter was heard by the UFRB and TRB on October 11, 2018. Below are the key findings, conclusions, and/or recommendations from the CIRP determined by the UFRB and TRB members and approved by the Sheriff.

### **Use of Force Review Board**

#### **UFRB: SWAT Officers Levi Hancock and Kai Hoskins**

The Board's finding was Administrative Approval. Administrative Approval is defined as, "objectively reasonable force was used under the circumstances based on the information available to the officers at the time. This finding acknowledges that the use of force was justified and within Department policy."

### **Tactical Review Board**

#### **Communication**

Communication can be verbal or non-verbal. It includes electronic transmission or in-person. A review of these recordings can provide valuable evidence of the circumstances surrounding a particular event.

Based on information given by officers and/or supervisors working this incident, the dispatcher documented the information in the computer aided dispatch (CAD) program appropriately.

- The administrative review determined Communications' management of CAD was within standardized LVMPD tactics, training, and policy.

Vital information related to Varnado was relayed from the family to patrol officers. Patrol officers relayed the information they obtained from the family to homicide detectives. During the briefing to SWAT, detectives communicated the pertinent information to SWAT. After the tactical plan was developed, it was back briefed by each SWAT officer. During the event, roles and responsibilities of each officer was repeated.

- The administrative review determined the information sharing between patrol officers, detectives, and SWAT were within standardized LVMPD tactics, training, and policy.

**Office of Internal Oversight Review**  
**Key Findings, Conclusions, and/or Recommendations of an Officer-Involved Shooting: Fatal**  
**7403 Newcrest Circle – November 6, 2017**

**De-escalation**

Policing requires that at times an officer must exercise control of a violent or resisting subject to make an arrest or to protect the officer, other officers, or members of the community from risk of harm. Clearly, not every potential violent confrontation can be de-escalated, but officers do have the ability to impact the direction and the outcome of many situations based on their decision-making and the tactics they choose to employ. As a strategy to diminish the likelihood and the severity of force, officers will attempt to de-escalate confrontations.

Officers coordinated with homicide detectives and developed a tactical plan to serve the search warrant at 7403 Newcrest Circle. The tactical plan was back briefed by the team members to ensure everyone understood the plan. Officers knew their roles and responsibilities during the service of the search warrant.

- The administrative review determined the preplanning was within standardized LVMPD tactics, training, and policy.

The SWAT Team arrived at 7403 Newcrest Circle in two Bearcats. The Bearcats parked on the northeast and northwest sides of the residence and provided cover for officers. Officers assigned as containment to the rear of the residence used cover and concealment when they approached. SWAT conducted a slow and methodical search of the residence. Additionally, they utilized various resources to de-escalate the situation.

- The administrative review determined SWAT's approach to the residence was within standardized LVMPD tactics, training, and policy.

As SWAT arrived at 7403 Newcrest Circle, they used a Bearcat and ballistic shields as cover while approaching the residence. SWAT used a robot and K9 dog to clear before they entered rooms of the residence. When SWAT officers entered a room, they used a ballistic shield.

- The administrative review determined the principles of cover and concealment used by SWAT was within standardized LVMPD tactics, training, and policy.

Prior to Officers Hoskins and Hancock entering Varnado's bedroom, officers had assigned roles and responsibilities. Officer Hoskins used the ballistic shield and his handgun as he entered the bedroom, while Officer Hancock transitioned from his rifle to hands on.

- The administrative review determined the principles of contact and cover used by Officers Hoskins and Hancock were within standardized LVMPD tactics, training, and policy.

**Use of Deadly Force**

It is the policy of this Department that officers hold the highest regard for the dignity and liberty of all persons and place minimal reliance upon the use of force. The Department respects the sanctity of every human life, and the application of deadly force is a measure to be employed in the most extreme circumstances where lesser means of force have failed or could not be reasonably considered.

**Office of Internal Oversight Review**  
**Key Findings, Conclusions, and/or Recommendations of an Officer-Involved Shooting: Fatal**  
**7403 Newcrest Circle – November 6, 2017**

The Department seeks to manage use of force beyond the *Graham v. Connor* (1989) standard and its minimum requirements by establishing further parameters for the application of force and to offer explicit direction to officers. Sound judgment, the appropriate exercise of discretion, and the adherence to Department policy will always be the foundation of officer decision-making in the broad range of possible use of force situations.

Officers will only use a level of force that is objectively reasonable to bring an incident or persons under control and to safely accomplish a lawful purpose. An officer's use of force must balance against the level of resistance exhibited by the subject. The level of force administered by an officer must be carefully controlled and should not be more than objectively reasonable to overcome the physical harm threatened.

In a confrontation, an officer will continuously reassess their response and adjust any use of force accordingly based upon the level of resistance encountered. Failure to reassess each application of force can lead to a violation of law and/or policy. The use of force by an officer must be within Department Policy which may be more restrictive than the U.S. Constitution.

The SWAT Team was serving a high-risk search warrant for a suspected double homicide suspect who had not responded to hours of verbal commands to exit the residence. Varnado ignored flash bang devices, an explosive breach to his bedroom door, and a K9 dog bite. SWAT officers had their weapons drawn as they searched 7403 Newcrest Circle due to the deadly threat posed by Varnado.

- The administrative review determined Officers Hoskins and Hancock's drawing of their firearms were within standardized LVMPD tactics, training, and policy.

At the time they used deadly force, SWAT Officers Hoskins and Hancock's backdrop was the floor.

- The administrative review determined Officers Hoskins and Hancock's assessment of their backdrop, target identification, and isolation were within standardized LVMPD tactics, training, and policy.

Varnado produced a handgun and aimed it toward SWAT officers as they entered the bedroom. Varnado's finger was on the trigger as he pointed his handgun at SWAT officers.

- The administrative review determined Officers Hoskins and Hancock's threat assessment were within standardized LVMPD tactics, training, and policy.

**Incident Management**

Supervisors will possess a thorough knowledge of tactics and ensure that officers under their supervision perform to a standard (in accordance with LVMPD policy and training). The prospect of a favorable outcome is often enhanced when supervisors become involved in the management of the overall response to a potentially violent encounter by coordinating officers' tactical actions.

Supervisors will acknowledge and respond to incidents in a timely manner when officer use of reportable force is probable. Supervisors will also manage the deployment of resources and equipment. In dynamic and highly-charged incidents, supervisors will provide clear direction and communication to officers

**Office of Internal Oversight Review**  
**Key Findings, Conclusions, and/or Recommendations of an Officer-Involved Shooting: Fatal**  
**7403 Newcrest Circle – November 6, 2017**

regarding their positioning and roles. Upon observing substandard officer approaches or flaws in tactical decisions, the supervisor will promptly act to correct any deficiencies.

The SWAT lieutenant was notified of the search warrant and directed a SWAT sergeant to develop a tactical plan. The SWAT sergeant and his assistant team leader (ATL) executed the tactical plan.

- The administrative review determined the SWAT supervisors' management of the incident was within standardized LVMPD tactics, training, and policy.

**Additional Key Findings, Conclusions and/or Recommendations**

LVMPD Tactical Medics were on the scene and as soon as Varnado was in custody, he was brought to the medics and medical intervention was provided. Varnado was transported by ambulance to UMC where he was pronounced deceased.

- The administrative review determined the medical response in this incident was within standardized LVMPD tactics, training, and policy.