OFFICE OF THE
CITY AUDITOR
ENSURING OPEN AND ACCOUNTABLE GOVERNMENT

CITY OF PORTLAND

Office of City Auditor LaVonne Griffin-Valade

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MEMORANDUM

Date: July 22, 2010

To: Mayor Sam Adams
Commissioner Randy Leonard
Commissioner Dan Saltzman
Commissioner Nick Fish
Commissioner Amanda Fritz

From: City Auditor LaVonne Griffin-Valade

Re: Accept the report of the OIR Group's review of the closed investigations of the death in custody of James Chasse, Jr.

As authorized in City Code 3.21, the Portland City Auditor and the Auditor's Independent Police Review (IPR) division issued an RFP in October 2009 for an independent expert/consultant to review the closed investigations relating to the death in police custody of James Chasse, Jr. Proposals from six qualified vendors were evaluated by a selection committee made up of two community members from the Citizen Review Committee, the City Auditor, and two staff members from IPR. OIR Group's proposal was selected in that process, and a contract was executed in January 2010.

Since mid January, consultants from the OIR Group met with Portland Police Bureau members, IPR staff, community members, and others significant to the investigations, many of whom were interviewed on multiple occasions. All investigatory materials and pertinent tactical, training, and procedural documents were provided to the expert consultants from the OIR Group for their review and analysis.

The final report from the OIR Group on the review of the closed investigations of the in-custody death of James Chasse, Jr. is attached. The report outlines a number of findings and makes 27 recommendations based on their review of the Chasse investigations. The OIR Group will present those findings and recommendations before City Council at 6:00 p.m., Wednesday, July 28 in Council Chambers.

Report to the City of Portland Concerning the In-Custody Death of James Chasse

Prepared by
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July 2010


OIR
GROUP

OFFICE OF THE
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Office of City Auditor LaVonne Griffin-Valade

Auditor's Independent Police Review Division
Mary-Beth Baptista, Director
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web: www.portlandoregon.gov/auditor/ipr

July 22, 2010

To: Mayor Sam Adams
Commissioner Randy Leonard
Commissioner Dan Saltzman
Commissioner Nick Fish
Commissioner Amanda Fritz

From: City Auditor LaVonne Griffin-Valade
Mary-Beth Baptista, IPR Director

Re: OIR Group – Report concerning the in-custody death of James Chasse

The in-custody death of James Chasse on September 17, 2006 was a significant event in this community. Concerns regarding the actions of the Portland Police Bureau and the other public and private entities involved with Mr. Chasse during the two hours between his initial encounter with law enforcement and his death in the back seat of a patrol vehicle have lingered for almost four years. For example, local officials, community members, and police officers have asked how this deadly force incident might have been prevented, and they have questioned why the internal investigations took three years to complete.

The City Auditor has had the authority to hire outside experts to review closed Police Bureau investigations of officer-involved shootings and in-custody deaths since 2002, and the Auditor's Independent Police Review division has overseen and published five of those expert examinations since that time. However, the attached review from the OIR Group is the first such report focusing on a single incident. It is also the first time a review was conducted prior to completion of civil litigation.

We broke with past practice in our approach to the expert review of Mr. Chasse's death for several reasons. Local officials and a broad spectrum of community members raised a number of procedural and policy issues, and over the course of the three-year investigation period, many called for greater transparency and responsiveness from the Police Bureau. The immediacy of the public's interest in this case was clear and compelling, prompting us to move forward with an expert review once the investigations closed in September 2009.

We also did not delay the expert review pending civil litigation because we have been convinced that to be meaningful and relevant to City officials, the Police Bureau, and the

public, such reviews should be timely, occurring as close to the event and investigations as possible. The primary purpose of these reviews is to determine what improvements should be made in existing police practices and tactical decision-making, as well as in the mechanisms used for police oversight. Waiting until civil litigation ends before conducting expert reviews undermines that goal, largely because civil law suits in these matters tend to go on for many years. Further, OIR group's report recommends that outside reviews of critical incidents should not be dictated by the pace of any resulting litigation. We concur, and in the future, we plan to launch expert reviews of all such cases at the close of investigations, contingent upon the availability of financial resources.

The report from OIR Group sheds considerable light on the Police Bureau's investigations of the events surrounding Mr. Chasse's death and makes substantive recommendations for change. We appreciate the thorough analysis and clarity in presenting the results of this important review, and we thank the OIR Group team members for their professionalism throughout and for their thoughtful attention to the unique qualities of this jurisdiction.

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Introduction

Nearly four years ago, James Phillip Chasse died tragically in the City of Portland as a result of his arrest and detention by Transit Division officers. Since that time, community members have struggled to understand how what started as a routine contact with police officers could have ended with such tragic consequences. While the public was understandably roiled by the initial accounts of the incident and the Medical Examiner's finding that the cause of death was blunt force trauma, the Portland Police Bureau promptly began an investigation to try to learn how and why this incident happened.

That those questions remained incompletely answered for so long only served to fuel the public's concern and growing frustration about the incident. The media correctly recognized that this incident struck a nerve and impacted the psyche of a community with a tradition for its caring and humanistic sensitivity in dealing with the mentally ill. Unfortunately, despite that history and in light of recent economic challenges impacting negatively on the public mental health safety net, this incident has taught that, more recently, too often it is a police officer, not a social worker, who is the first responder to a person in crisis. As we see below, as this case unfolded, the Bureau soon recognized that its officers did not have the tools and training to deal optimally with such individuals. It is hoped that the Bureau-mandated training provided to each officer in response to this incident may have changed perspectives so that chase and apprehend is not necessarily the first response in the future in dealing with individuals like Mr. Chasse.

In reviewing the account of the incident presented here and our critiques and recommendations, we provide the reader a few preliminary observations. First, it must be recognized that the Portland Police Bureau of 2010 is not the Portland Police Bureau of 2006. As we discuss more fully in our Report, critical systemic reform, much arising out of this incident, has improved the investigative processes, policies, training, and review that we critique below. Second, unlike most comparable police agencies, PPB has a long regarded tradition of opening up its vault of materials and personnel to exacting outside review. The Bureau's orientation and acceptance of recommendations from those independent voices has left the Bureau head and shoulders above most comparable agencies with regard to the way in which it investigates critical incidents and most importantly, the way in which it reviews and learns from

them. There still remain too many police agencies that perform, at best, a cursory investigation of a critical incident and whose review consists of the Chief placing a "duly noted" stamp on that investigation and finding a place for the report in a file cabinet. PPB is not one of them.

Despite the Bureau's comparatively excellent processes for investigating and reviewing critical incidents, we found much room for continued improvement of those processes. Missed investigative issues, review issues, policy issues, training issues, systemic issues, and the inordinate delay in the completion of the investigative process are all catalogued here. The recommendations we offer are intended for the Bureau to consider additional ways in which it can continue to improve on all of those processes.

Some might suggest that our review is simply Monday-morning quarterbacking and that we were not present in real time to face the challenges of the involved officers, the investigators, and the Bureau's reviewers and executives in dealing with this unprecedented case. Our response is to not only accept that point but embrace it; the most important thing a police agency can do in response to a tragic outcome is to perform an exacting investigation and review so that the organization and its officers can be better trained and equipped to deal with tomorrow's circumstances. We are hopeful that our subsequent independent review will provide another opportunity for introspection for the Bureau with respect to this incident, so that it can continue to refine and improve the way in which it investigates and reviews critical incidents. To the degree the PPB investigation and review left issues unidentified and unaddressed, our review is intended to fill in those gaps so that the Bureau can consider them at this time.

To those in the public, we offer this Report as an independent account of the Chasse incident and how the Bureau investigated and reviewed the matter. To the degree we point out weaknesses and deficiencies in those efforts, it is balanced by the Bureau's self-examination and proactive measures. Perhaps the best testament to the Bureau and the City leaders' openness was the cooperation that allowed us to effectively do our work and their willingness to have each of our findings and recommendations presented to their public.

I. Summary of Findings

On September 17, 2006, a Portland Police Bureau officer and a Multnomah County Sheriff's deputy contacted James Phillip Chasse, who ran from them as they pursued him on foot for a short distance. The officer forced him to the ground, where the deputy and a Portland Police Bureau sergeant joined the officer in a struggle to handcuff Mr. Chasse. Mr. Chasse died later that evening as a result of this encounter.

The Bureau responded to this incident by initiating a Homicide investigation and submitting the evidence to the District Attorney for presentation to the Grand Jury. Though we offer several recommendations for improved documentation and timeliness of interviews, we found the work done by Detectives to be thorough, exacting and relatively swift. Our key recommendations regarding the Homicide investigation include:

- Taking the necessary steps to interview involved officers contemporaneously with the incident;
- Conducting face-to-face interviews with civilian witnesses soon after the incident;
- Addressing the need to have private ambulance personnel cooperate with in-custody death investigations;
- Documenting the transport of officers from the scene;
- Adding Internal Affairs personnel to the roster of those expected to respond to the scene of the incident.

The Internal Affairs Division interviews were thorough and fair but the investigation suffered significant delays because of the length of time Homicide took to complete its investigative book and forward to IAD, staffing shortages at IAD, and Multnomah County's decision to not let its employees be interviewed by investigators until after they had been deposed in the civil case. Moreover, the IAD investigation – which received an unusual amount of attention and intervention from Bureau executives – had significant gaps in information gathering, including insufficient attention to the jail videotape; the lack of attention to alleged

on-scene conduct by Bureau personnel, including allegations of inaccurate information about Mr. Chasse being conveyed to a civilian; the failure to interview all of the officers who assisted in restraining and carrying Mr. Chasse; the failure to sufficiently follow up on the delay in taking Mr. Chasse into the jail while the involved officers completed paperwork; and the failure to attempt to question jail personnel about any statements made by the involved officers.

We offer several recommendations intended to help the Bureau avoid similar delays in future cases and ensure a robust IAD investigation. Among these:

- Creating internal policy to ensure timely completion of the Detectives' notebook and timely handoff of materials to IAD;
- Drafting internal policies recognizing the importance of the IAD function and ensuring that essential resources not be diverted away from the unit;
- Enlisting the assistance of its Commissioner and/or City Council when encountering investigative roadblocks created by outside government agencies;
- When a witness may be unavailable for a lengthy period of time, considering whether the investigation should proceed apace with the information already available;
- Having IAD work more closely with the Detectives on scene to ensure a more thorough collection of facts and exploring of issues at the criminal phase of the investigation;
- Encouraging IAD to explore and develop any potential supervisory issues as part of its critical incident review;
- Forging an agreement with other agencies that ongoing civil litigation should not be a reason for refusing to provide PPB access to their personnel.

Our report comments favorably on the well-considered training analysis that was prepared relating to this incident. We did note several issues that were not explored in the analysis, namely the involved supervisor's failure to hand off command of the scene to an uninvolved supervisor, the potentially harmful manner in which Mr. Chasse was carried to the patrol car, and the lack of a breathing guard in the patrol car when officers were attempting to

render first aid. We also found that when new information was brought forward as a result of the enhanced videotape, a revised training analysis should have been completed. With regard to those missed training issues we recommended that the Bureau revisit them and consider whether:

- A directive should be devised requiring that any supervisor directly involved in a significant use of force relinquish his or her role as incident commander once an uninvolved supervisor responds;

- Policy and training should be revised regarding the transport and carrying of subjects in maximum restraints;

- When new evidence is to be considered, the Training Division should update and revise its analysis based on that new information.

With regard to the Use of Force Review Board, we found that the Board provides an objective mechanism through which issues of accountability, training, systems review, supervision, and equipment can be effectively assessed. That being said, we offered the following recommendations designed to improve the Board's quality of review:

- A reconsideration of the advisability of encouraging involved officers to appear before the Board and when they do appear, limiting the scope of presentation to facts;

- Notifying all Board members of the final outcomes of cases in which they participate.

Throughout our review, we heard repeatedly that Transit Division had a particular way of doing business that set it apart from the rest of the Bureau and gave license to tactics not supported by Training or condoned in other divisions. We also heard that this was a direct response to community expectations and Transit Division's mission to eliminate drug sales and nuisance crimes from on and around the transit system. We believe the Bureau should:

- Take action to evaluate these differences, to the extent they still exist;

- Ensure future timely and complete cooperation of non-Bureau officers in Bureau in-custody death investigations;

- Work with the other agencies whose officers work in the Transit Division to agree upon a common core of accepted tactics and training and provide that training to all Transit officers.

The Bureau already has instituted a number of remedial measures to address some of the training and tactical issues and policy deficiencies this case presented. It did so quickly and on its own initiative. While the Report offers several suggestions for improvement of the Bureau's new policies and training initiatives, we applaud the Bureau's efforts to learn from the Chasse case and use it as a vehicle for change. Most notable among these are:

- Mandatory Crisis Intervention Team training for all officers;
- Training officers to consider the severity of the crime before initiating a foot pursuit;
- Requiring officers to give paramedics complete information before deciding how to transport subjects;
- Roll-call videos on foot pursuits, Taser use, and other subjects.

We also examined the Bureau's decision to hire the involved deputy during the pendency of the in custody death investigation and recommended that it consider developing a policy of not hiring lateral candidates while they are under investigation.

Finally, we examined the role of IPR in the review of the Chasse incident and noted the evolution of the City Auditor's oversight entity. Consistent with that evolution, we recommended that:

- IPR continue in its dialogue with the Bureau to develop a protocol in which it regularly responds to critical incidents;
- Consider establishing a more visible and public presence during the pendency of a critical incident investigation.

II. Scope of Review

In October, 2009, the Portland City Auditor and the Auditor's Independent Police Review Division ("IPR") caused the City of Portland to issue an RFP for an independent expert/consultant to review the internal investigations relating to Mr. Chasse's death, to analyze the Bureau's relevant training and policies, and to evaluate the Bureau's administrative response. OIR Group replied and was eventually selected to perform this review and analysis. We are pleased to report that we received complete access to PPB reports, documents, photographic and video evidence, and forensic evidence pertaining to the Chasse in-custody death. We reviewed current and previous PPB policies and procedures as well as training documents and videos. We interviewed Detectives and Internal Affairs investigators, training staff, command staff, PPB executives and former executives, government attorneys, and IPR staff. We also met with community groups and members of the Citizen Review Committee, and spoke with citizen members of the Use of Force Review Board. Throughout our review, we received complete cooperation from PPB members and all other stakeholders who responded candidly to our questions. As called for in the RFP, we also reviewed reports and recommendations from the Police Assessment Resource Center ("PARC") that have been prepared periodically since 2003.

This report intends to discuss the facts surrounding the police encounter with Mr. Chasse only to provide the necessary background and framework for our discussion of the Bureau's investigative response, relevant policy issues, and corrective actions. We were not engaged nor would it be appropriate for us to provide an after-the-fact opinion on the correctness of the outcome of the Bureau's administrative decision making process. Rather, we focus on how the Bureau investigated this in-custody death and what it learned for purposes of accountability and systemic reform. Throughout, we make recommendations intended to improve the Bureau's future performance and response to such critical incidents.

III. Summary of the Facts

On September 17, 2006, a Transit Police Division team consisting of one Portland Police Bureau officer and one Multnomah County Sheriff's Office deputy[1] were working a routine patrol assignment when they stopped to assist a PPB sergeant during his contact with an individual near NW 18th and NW Everett in the City of Portland. During that contact the officer noticed another individual, later identified as Mr. Chasse, standing nearby. His initial impression was that Mr. Chasse was transient and, because of the way he moved, likely intoxicated. The officer stated that Mr. Chasse appeared to notice them and then quickly walked away, leading him to suspect that he had an outstanding warrant and wanted to avoid police contact. He told the sergeant and deputy about his observation and stated that they should try to stop him if they were later provided the opportunity.

The opportunity to stop Mr. Chasse presented itself within minutes. After they cleared the original call, the sergeant drove off while the officer/deputy team left in a separate patrol car. The officer and deputy again saw Mr. Chasse near the 1300 block of NW Everett. At this time, the officer observed Mr. Chasse with his back to him in a manner that suggested to the officer that Mr. Chasse was either urinating or possibly injecting drugs into his hand. The deputy described Mr. Chasse as hunched over, as though he might be trying to discard drugs. The officer stated he was concerned about the public's safety, Mr. Chasse's welfare with regards to the possible intoxication, and the likelihood that Mr. Chasse had an outstanding warrant. The deputy reiterated these same concerns, but also added that he thought Mr. Chasse might need to talk to Project Respond, the mobile mental health crisis response team for Multnomah County. The officer and deputy decided to contact Mr. Chasse, so the deputy stopped the car and they exited the vehicle and approached Mr. Chasse on foot. The deputy called out to Mr. Chasse, who turned his head, looked at the officers with a terrified expression, and then ran. The officers immediately pursued.

[1] This deputy is now a PPB officer, after having been hired by the Bureau shortly after this incident. For ease, we will continue to refer to him as a deputy throughout this report.

Within approximately 30-40 feet, the PPB officer caught up to Mr. Chasse. Accounts vary on the manner in which Mr. Chasse was forced to the ground. The officer described using the "knock down technique," developed by Training as a preferable alternative to grabbing someone to take them to the ground and end a foot pursuit, and shoved Mr. Chasse in the back, causing him to stumble and fall forward. Other witnesses report seeing the officer wrap Mr. Chasse up in a bear hug type of tackle, or according to one witness, take him down with a flying tackle. Two civilian witnesses described seeing three policemen chasing the subject then all falling to the ground together with the subject. The end result was the same – Mr. Chasse fell hard to the pavement. The officer also fell to the ground, either as a result of the tackle or because he lost his balance as he knocked Mr. Chasse down. In statements made to paramedics at the scene, the officer steadfastly denied that he had landed on Mr. Chasse when he fell. In his later Homicide and Internal Affairs Division (IAD) interviews, he allowed it was possible that some part of his body had landed on Mr. Chasse. In a video recorded later that evening in the jail holding cell area, the deputy appears to demonstrate in the officer's presence a takedown similar to a bear hug tackle. The forensic evidence suggests that the officer did fall on top of Mr. Chasse, and the City's position in the litigation was that Mr. Chasse's most serious injuries were the result of the officer landing on him at the end of the foot pursuit.

The involved sergeant observed the officer and deputy chasing Mr. Chasse, and stopped and exited his vehicle to assist. The sergeant was in front of the pursuit at the time and intended to intercept Mr. Chasse. Instead, he watched as Mr. Chasse and the officer went to the ground, and then got involved in the struggle to secure Mr. Chasse. Ultimately, the officers restrained Mr. Chasse with handcuffs and a hobble device that secured his legs and attached to his wrists behind his back.

There are conflicting reports and observations about the force the officers used in their efforts to restrain Mr. Chasse. According to the reports of the officer, deputy, and sergeant, the officer used an arm bar to try to control one of Mr. Chasse's arms, punched him in the face with a closed fist, and pushed and pulled at his shoulders. The deputy attempted to control Mr. Chasse's legs, struck Mr. Chasse in the back with a closed fist, drove his knuckle into his back rib area as a pain compliance technique, and used a Taser in the drive-stun mode on Mr.

Chasse's thigh or buttocks area, which seemed to the officers to have no effect. The sergeant also reported using force during the struggle: he kneeled on Mr. Chasse's shoulders and/or back in an attempt to pin him, attempted to control one arm with a wrist lock, kicked him in the chest and then put the sole of his boot against Mr. Chasse's jaw (in response to Mr. Chasse biting him on the calf).

Civilian witness accounts vary on the type and amount of force used. One witness described a "chaotic struggle" in which Mr. Chasse twisted and turned and displayed a great deal of energy while officers, surprisingly, could not restrain him. At the same time, it appeared to that witness as if the kicks and blows she saw the officers deliver were unnecessary, as it appeared to her the Taser effectively brought Mr. Chasse under control by rendering him unconscious. Another civilian witness described seeing officers punch and kick the subject in the head. Another witness observed officers press their knees on Mr. Chasse's shoulders, neck and legs. Other witnesses also described the intense struggle to restrain Mr. Chasse. One saw him attempt to bite an officer. Another heard an officer say, "Don't bite me."

Once Mr. Chasse was restrained, it appeared to the officers that he had a brief period of unconsciousness. They called for paramedics to respond. Two paramedics from the private ambulance company American Medical Response ("AMR") arrived first, followed by two Portland Fire paramedics. The involved PPB sergeant took the lead in communicating with paramedics. He informed them Mr. Chasse had run from and fought with police and had been momentarily unconscious, but did not provide any details of the struggle, including that the Taser had been used. When interviewed, the AMR paramedic with whom the sergeant communicated said the officers were cooperative and she felt she had all the information she needed to assess Mr. Chasse. Though Mr. Chasse was conscious but not responsive to any of their questions and struggled with the paramedics, his vital signs – pulse, respirations, blood pressure – were all within normal limits. The paramedics additionally administered a blood glucose test, which also was normal. One AMR paramedic advised the sergeant Mr. Chasse appeared to be fine and could be transported to jail, but also offered to transport him to the hospital. She asked the officer to sign an AMR Information Form, which is a form given to patients who decline to be

transported by Emergency Medical Services ("EMS"). While the officer thought the request was unusual, he agreed to sign the form for Mr. Chasse.

The PPB officer and sergeant, along with one or two other officers, then carried Mr. Chasse to the patrol car, approximately 30-40 feet away. The vehicle had not been moved since the deputy stopped it to contact Mr. Chasse initially. Mr. Chasse remained in maximum restraints and was carried face down, with one officer at each armpit. Mr. Chasse struggled while being carried, screaming and pulling against the restraints and attempting to bite the transporting officers. The officers believed Mr. Chasse's aggressive, erratic behavior indicated he was on drugs. They did not consider that he might be mentally ill. The officer and deputy secured him in their patrol vehicle and transported him to the Multnomah County Detention Center ("MCDC") without further incident.

One civilian witness mentioned that after she watched Mr. Chasse being carried away, a PPB officer asked if she wanted to know what had happened, then volunteered that the arrestee had 14 narcotics convictions and the officers had found cocaine on him. We now know this alleged account by a PPB officer of Mr. Chasse's criminal history was not true. No other civilian witnesses reported hearing this or any similar comments, though some were troubled by what they perceived as laughing or joking by officers and paramedics.

When they arrived at the jail with Mr. Chasse, the officer and deputy parked in a lot across the street to complete the Custody Report and Property Receipt before driving to the jail's sally port. At the jail, the officer and deputy, with the assistance of three other MCSO deputies, placed a spit hood on Mr. Chasse to prevent him from biting and carried him into a cell, where the handcuffs and hobble restraint, but not the spit hood, were removed. In the cell, Mr. Chasse appeared to again lose consciousness, though he continued to breathe. Two nurses assigned to MCDC looked at Mr. Chasse through the window in the cell door, then advised the officer they would not clear him for admittance to the jail and that he needed to be transported to the hospital for evaluation. At least one of the nurses saw Mr. Chasse experience what appeared to be a brief seizure and overheard that he had briefly lost consciousness. The nurses did not advise the officer to call for an ambulance. The officers and deputies then carried Mr. Chasse – in handcuffs and leg chains, but not hobbled or in maximum restraints – back to the patrol car.

The officer visually monitored Mr. Chasse on the drive toward Portland Adventist Hospital. On the freeway, he appeared to stop breathing, so the deputy exited the freeway and requested an ambulance. He stopped the car at NE 33rd and NE Clackamas Street and pulled Mr. Chasse out from the backseat. They removed the spit hood, the deputy swept Mr. Chasse's mouth for obstructions to his airway, and the officer began chest compressions. The deputy looked for a breathing mask so that he could administer breaths, but could not find one. A resident from a nearby house came out with an Automated External Defibrillator (AED), which is used to administer an electric shock to someone in cardiac arrest. He attached it to Mr. Chasse, but the machine's computer advised not to administer the shock. Portland Fire and AMR (different paramedics) responded and AMR transported Mr. Chasse to the hospital, where he was pronounced dead a short time later. From the time officers first contacted Mr. Chasse at NW 13th and NW Everett, the incident lasted just under two hours.

The State of Oregon Medical Examiner conducted an autopsy the next day and determined the cause of Mr. Chasse's death to be blunt force chest injuries.[2] Specifically, Mr. Chasse had 27 fractures of 14 ribs. Some of those fractures were displaced and three penetrated the left lung, causing intense hemorrhaging. During her interview with IAD, the Medical Examiner elaborated on Mr. Chasse's injuries. In her opinion, ten of the rib fractures were caused by chest compressions administered in attempts to resuscitate Mr. Chasse. None of these fractures contributed to Mr. Chasse's death. According to the Medical Examiner, the best way to explain the other 17 fractures, all along the back, is that they occurred with a single broad-based application of force, such as someone or something falling on top of Mr. Chasse, and not from individual blows. She based this conclusion on the location of the fractures and the fact that there was no evidence of corresponding external injuries (contusions or lacerations) that she would expect to see if the ribs had been fractured by individual blows. She also noted that Mr. Chasse's bones were very fragile and brittle, more like those of a 60- or 70-year-old woman than a 45-year-old man, concluding it would have been easier to break Mr. Chasse's bones than one would expect.

[2] Our observations are based on the Medical Examiner's report and her interview with IAD.

The Medical Examiner at first questioned the reports that Mr. Chasse's vital signs were within normal range, because such normal readings are inconsistent with the injuries she found to Mr. Chasse's body. When IAD investigators showed her documentation from AMR verifying the various readings, she opined that the readings, while within normal limits for most people, may not have been normal for Mr. Chasse. She also opined that the ribs may have been fractured but not displaced at the time of the initial blunt force trauma, so that the lung was not punctured at the time Mr. Chasse was examined by the paramedics at NW 13th and NW Everett, but that the way in which Mr. Chasse was moved about – carried to the car and into and out of the jail – exacerbated the rib fractures and caused the internal injuries.

Later, during the course of the investigation, Detectives learned that a PPB officer had accompanied a mental health worker from Project Respond to visit Mr. Chasse at his apartment two days before his death. That visit had ended abruptly when Mr. Chasse fled from his apartment building and from the officer and the mental health worker.

IV. Homicide Detectives' Investigation

A. Detectives Activities

The PPB Detectives responsible for investigating the in-custody death arrived at the NE Clackamas Street scene within about 30 minutes of the time Mr. Chasse was pronounced dead. The process that resulted in the alert to Homicide Detectives actually began prior to Mr. Chasse's death. While Mr. Chasse was being removed by paramedics from the NE Clackamas Street scene to the hospital, a patrol sergeant on scene at NE Clackamas Street apparently concluded that his death could be imminent and contacted the precinct which, in turn contacted the sergeant handling the Homicide team. While en route and soon after arriving at the NE Clackamas Street scene, the Homicide sergeant summoned an investigative team that included six Homicide Detectives and three Detectives from the East County Major Crimes Team as well as crime scene technicians and photographers to document and measure the scene and to collect evidence at the

direction of the Detectives. He also called the District Attorney's Office and requested a Deputy DA on scene.[3]

The Detectives' reports indicate that when they arrived on scene, they immediately ensured that the involved officers had been separated and began directing the photographing and processing of the scene. They learned the basic details of the events leading up to Mr. Chasse's death, and then the lead investigators quickly moved to the arrest scene at NW 13th and NW Everett.

The Detectives asked each of the involved officers, the sergeant and the deputy if they would submit to an immediate interview about the incident and/or participate in a "walk-through" of the scene, during which an officer will point out what happened where. Consistent with usual practice and upon the advice of their union attorneys, each of the involved officers and deputies declined to be interviewed that evening, although one of the involved officers agreed to participate in a walk-through of the arrest scene. He pointed out to detectives the location where he first saw Mr. Chasse and other critical locations in the incident. Detectives did interview all of the witness officers that evening – that is, those who had not been directly involved with the arrest of Mr. Chasse but had arrived at the scene soon after – as well as deputies working at the Multnomah County Detention Center who had been present when Mr. Chasse was first brought in by the arresting officers.

Detectives collected as evidence the deputy's Taser and the defibrillator machine, among other items. The Homicide sergeant determined that there were four separate paramedic teams that had been involved with Mr. Chasse, two from AMR and two from Portland Fire Bureau, and asked to have both AMR teams come to the Detective Division for interviews later that evening. A representative for AMR, the private ambulance company, replied that the AMR paramedics would not be willing to give statements to Homicide at that time.

The day following Mr. Chasse's death, Detectives interviewed the sergeant originally involved in the arrest of Mr. Chasse as well as the officer who first made physical contact with

[3] Commanders of both the Transit Division and Central Precinct also responded to the scene that evening.

him. They also attended the Medical Examiner's autopsy where the Medical Examiner shared her conclusions that blunt force chest injuries had caused Mr. Chasse's death. She pointed out multiple rib fractures and blood fluid in his left lung from penetration by broken ribs.

Detectives also made another attempt to arrange interviews with the AMR paramedics and were told by a supervisor for the company that access to EMS staff would not be granted and requested reports and records would have to be subpoenaed.

That day, Detectives interviewed the nurse at the jail who had refused to allow the officers to book Mr. Chasse into the jail and had insisted that he be taken to the hospital for evaluation.

The following day, two days after Mr. Chasse's death, Detectives interviewed the remaining officer and the deputy who had been among the original five officers who put hands on Mr. Chasse during his arrest and transport to the jail as well as his transport to the hospital.

Over the next two weeks, Detectives interviewed 14 civilian witnesses. All of these interviews were conducted by telephone. During this period, Detectives also conducted face-to-face interviews with four Portland Fire Bureau personnel, employees of the City-operated paramedic team that had responded to the arrest scene.

B. Organization and Pace of the Investigation

Homicide was notified by the Bureau when there was yet only a strong likelihood that a death in custody investigation would be required. To his credit, the Homicide supervisor began assembling a team immediately and, when he learned within a few minutes that the incident involved multiple locations and more than one agency, he expanded the investigative team and sent groups of detectives to the various scenes. The investigative team grew to six Detectives and two sergeants working under Homicide's umbrella plus four Detectives from the Sheriff's Office. The Detectives quickly identified the relevant witnesses, both sworn and civilian. There was also careful documentation of evidence collection and attention to some potentially important details, for instance, assigning a detective to accompany the involved officers' car as it was towed from the NE Clackamas Street scene and to document any personnel who opened it or touched the interior during that process.

Some aspects of the investigation, however, appear to have proceeded more slowly. Two of the five key sworn witnesses were not interviewed until two days after the incident. None of the civilian eyewitness interviews were begun until four days after the incident. Some of them took place several days later. Virtually all of them were conducted by telephone. While some of these 14 civilians did not come forward until days after the incident, several were identified immediately, especially the employees of the nearby restaurant. Given the large number of nearby, independent witnesses to this daytime arrest, it likely would have been more productive to interview these eyewitnesses earlier in the process. Because the immediate response by Homicide investigators was not to the arrest scene, it may have been impracticable to conduct eyewitness interviews by the time investigators arrived. However, if so, the impracticability of such an approach should have been documented in the file. Additionally, in a case where lines of sight and proximity to the action are important, telephone interviews are clearly less desirable than a face-to-face interview, preferably at the scene.

Recommendation: The Bureau should consider adopting internal protocols for in-custody death investigations that recognize the advantage of on-scene face-to-face interviews for civilian eyewitnesses and the need to conduct those interviews shortly after the incident has occurred if practicable. If conducting such interviews immediately after the event is not practicable, that fact should be noted in the investigative file.

C. Delay of Involved Officer Interviews

The five primary officers involved in the arrest of Mr. Chasse – including two who arrived after the foot pursuit and helped hobble and then carry Mr. Chasse – all declined to be interviewed on the day of the incident. This is allowed by law during the criminal phase of the investigation, as officers have a Fifth Amendment right to refuse to talk to a criminal investigator. The general custom among PPB officers is to decline to be interviewed immediately after the incident. Each of the PPB officers and the MCSO deputy followed that pattern. This is regrettable in our opinion because the fresh impressions of the participants may be lost with the passage of time. Moreover, the separation and chaperoning of involved officers immediately after a critical incident, which PPB pursues conscientiously, is potentially rendered ineffectual by an interview delay of one or two days. PPB employs a "Communication

Restriction during Investigation" form to admonish officers not to talk about the facts of the incident with other officers before they are interviewed. This is a laudable way of documenting this message but it does not adequately address the possible appearance of an opportunity for officers to collude created by the delayed interviews of involved officers.

Recently, in support of law enforcement, a few academics have suggested that it may be preferable to wait a day or more before obtaining a witness interview from officers involved in critical incidents. The argument draws support from memory studies that suggest individuals involved in a high stress incident may actually have a better ability to articulate and recall certain events a day or two after the incident, once the stress of the situation has dissipated. If these studies are true, it would suggest that best investigative practices should uniformly avoid interviewing any witness about a stressful incident until a day or two has lapsed. However, we have seen no similar protocol being advocated that would uniformly delay for a day or two a witness interview of a bank teller who was victimized by a bank robber, a witness interview of the victim of an aggravated assault, or an interview of a person who witnessed a carjacking, even in cases in which the suspect has been apprehended. To carve out an investigative "wait" exception so that law enforcement officers, persons especially trained to be professional witnesses, can collect their thoughts before telling their Bureau what occurred runs against general investigative principles that call for obtaining early statements from witnesses and gives too little weight to the abilities of police officers to relate such information relatively quickly.

Another argument toward preserving the status quo is that in Portland police officers have regularly agreed to be voluntarily interviewed by Homicide investigators, albeit a day or two delayed, and that to attempt to change current protocols could cause officers to no longer agree to a voluntary interview. Of course, the Bureau could compel officers to submit to interviews the night of the incident; but that interview would not be available to the District Attorney. While certainly there is value in obtaining voluntary interviews, one must weigh the advantage of having a voluntary interview a day or two after the incident against gaining an account from the involved officers the night of the incident. Moreover, in our experience, the concern that officers will stop agreeing to voluntary interviews if interviewing protocols are modified usually is not borne out. There are certainly inherent advantages for officers to agree to

voluntary interviews and provide to the District Attorney his or her version of what occurred, particularly in the vast majority of cases that do not come close to implicating criminal conduct. To suggest that officers will stop providing this information to the District Attorney if the Bureau wants to obtain the information the night of the incident may undervalue the officers' interest in having his or her version of the event readily available to the District Attorney.

This being said, we have been informed that the current Bureau labor contract provides that involved officers are not to be interviewed contemporaneous with the incident. We also understand that union attorneys have been more accommodating recently and have allowed Detectives to interview officers the day after the incident, as occurred with regard to some of the involved personnel in this case. However, protocols that would afford the Bureau to be able to obtain a statement from officers the night of the incident about what had transpired would help the fact finding process and provide increased public trust in the Bureau's critical incident investigations.

Recommendation: The Bureau should consider initiating discussions with the union to reform protocols so that involved personnel can be interviewed about their actions contemporaneous with the incident.

Additionally, we observed that the sequestering/monitoring of the officers back at the precinct after the incident was well documented but there was no documentation of their transportation from the scene.

Recommendation: The Bureau should consider revising internal investigative protocols so that the transport of officers from the scene is documented.

As noted above, one of the involved officers did agree to participate in a walk-through of the arrest scene immediately. The walk-through and any statements made by the officer were only scantily documented, as Detectives strove to avoid any suggestion that they were attempting to interview the officer.[4] Nonetheless, the walk-through doubtless provided the Detectives with

[4] If a walk-through begins to resemble a full-blown interview, there is a greater likelihood that the officers will decline to participate.

a very useful early picture of the location and general outlines of the arrest. The Detectives do not indicate why they did not ask the officer to walk through the NE Clackamas Street scene also, though it seems logical that the officer might very well have been willing to do for both scenes what he had just done for one.

The Detectives' interviews were generally focused, thorough, and unbiased. We observed some use of arguably leading questions, such as when one officer was asked if he noticed if another officer had picked something up off the ground as evidence, but no overtly suggestive or coercive questioning. We observed one potentially important oversight in the interviews of the officer and deputy who initiated the chase and apprehension of Mr. Chasse as well as performing chest compressions on him later. Both interviews took place soon after the Homicide Detectives attended the autopsy and spoke to the medical examiner. They were aware that the medical examiner had determined that the cause of death was blunt force injuries to the chest and ribs and that many ribs were fractured. It is logical to expect that this should have caused Detectives to focus more intently upon the initial take down and the use of chest compressions during CPR at the NE Clackamas Street scene. The interviews of the officer and the deputy however spent little time on this part of the action. They did not delve into the sensations or sounds that might have emanated from Mr. Chasse's chest and did not grapple with how these routine police actions could have produced what would have seemed at the time like disparately great chest injuries.

At least one witness who was not interviewed, however, represents a small but conspicuous gap in the Detective investigation. One of the two nurses at the jail, who apparently had the opportunity to make observations and evaluations of Mr. Chasse, was not interviewed. She might have been able to address some crucial questions about the arrestee's symptoms and appearance and any statements made by the involved personnel about the arrest incident.

As noted above, Detectives identified the two ambulance paramedic teams and attempted to interview them on the night of the incident. The AMR paramedics, apparently on the advice of their employer, declined. The Homicide team persisted the next day and spoke to an AMR supervisor, to no avail. They tried again when a detective encountered the company attorney at the Grand Jury proceedings, again without success. This evident interest in the fresh statements

of the AMR personnel was certainly well placed given their presence and participation at two critical points in the chain of events that ended with Mr. Chasse's death. Their vital vantage point and expertise makes their refusal to participate in the investigation all the more disappointing. While ambulance paramedics form part of the emergency services infrastructure, they are not public employees and in this instance their employer's concerns about liability evidently took precedence over all other concerns. The Homicide Detectives made an earnest and persistent effort to persuade the company to cooperate but their appeal to civic duty evidently did not carry sufficient weight to overcome those concerns. Given the key role that ambulance personnel may likely play in future critical incidents as participants, as medical experts and as experienced witnesses independent of law enforcement, it behooves the Bureau and the City to consider initiating discussions with the private ambulance company to determine whether protocols can be adopted ensuring the cooperation of personnel with any subsequent PPB in-custody death investigation.[5]

Recommendation: The Bureau and the City should consider initiating dialogue with AMR to develop protocols ensuring future cooperation of the private ambulance company in PPB in-custody death investigations.

D. Personnel Responding to Scene

The Internal Affairs Division has not regularly responded to the scene of critical incidents. We have been informed that, in the past, IAD personnel did respond to some scenes but IAD command found little advantage to doing so. It is unclear to what degree IAD personnel who did respond had access to the scene and whether they were able to participate in a walk-through or obtain an on-scene briefing by Homicide Detectives. Moreover, as noted elsewhere in this report, IAD only recently began actively conducting its own investigation as opposed to simply repackaging the Homicide investigation. With its enhanced duties, the advantages of

[5] To their credit, responding personnel from the Portland Fire Department did agree to be interviewed by Homicide Detectives. With regard to the two ambulance crews from AMR, while they were eventually subpoenaed and testified before the grand jury, it would have been helpful to the investigation if Homicide had been afforded an opportunity to interview personnel prior to their grand jury testimony.

IAD personnel being able to observe conditions close in time to the incident rather than to have to rely entirely on photographs, diagrams, or investigative reports is greater than in years past. Moreover, the more active role IAD is playing in independently developing facts related to administrative issues calls for a presence at the scene so that it can dialogue with its Detective counterparts and ensure that evidence that may be unimportant for purposes of the criminal review is collected and preserved for purposes of the administrative investigation.[6]

It would have been advantageous to have IAD investigators present at the scene in the Chasse case for a number of reasons. First, IAD investigators would have had early access to the basic facts of the incident, somewhat mitigating the fact that IAD did not receive the Homicide Detectives' notebook until four months after the Grand Jury. Also, IAD investigators would have been in a better position to identify witnesses and gather information concerning the allegation that officers were behaving improperly and spreading misinformation about Mr. Chasse, an issue that was peripheral to Homicide's task. Finally, IAD investigators would have been able to identify witnesses from MCDC and, if not interview them, at least consult with Detectives about the scope of questioning.

It is our understanding that IPR is currently involved in discussions with the Bureau that may result in IPR regularly responding to the scene of critical incidents. We support this initiative. As a result of the increased role being played by IPR in ensuring thorough investigations and reviews of critical incidents, it will be helpful for IPR to travel to the scene to gain an early understanding of the potential issues presented by the incident. Moreover, the rapid response evidenced by IPR rolling out to these incidents provides both a real and symbolic message to the public of IPR and City Auditor's commitment to its responsibilities and is indicative of a robust independent oversight mechanism.

The likely regular presence of IPR at critical incident scenes is yet another reason for the Bureau to consider again having an IAD representative travel to the scene. In most cases, IPR's ability to identify issues and provide real-time advice regarding critical incidents is conveyed

[6] Some police agencies have policies ensuring dialogue at the scene between criminal and administrative investigators so that evidence important to the administrative case is timely collected.

through IAD. As the incident unfolds and issues become known to IPR, the Bureau would be well-served to have IAD also present at the location to discuss these issues with IPR.

Recommendation: The Bureau should consider revisiting the idea of having IAD representatives respond to in-custody death scenes. The Bureau should continue to work with IPR to develop protocols so that IPR can become a regular part of the response to in-custody death scenes.

V. Internal Affairs Division Investigation

A. Timeline of the Investigation

Following the conclusion of the criminal case, investigators from the Internal Affairs Division ("IAD") were assigned to investigate Mr. Chasse's death administratively, looking at the question of whether officers had violated any PPB policies in their contact with Mr. Chasse. Unfortunately, it took IAD approximately seven months to begin its work, and then it confronted delays associated with the ongoing civil litigation, so that IAD did not complete its investigation until July 2008 – 22 months after Mr. Chasse's death.

The initial delays in the IAD investigation stemmed from what appear to be both systemic and individualized problems within PPB. When Detective Division completes its investigation, it quickly hands its materials over to the District Attorney's office so the case can be presented to the grand jury. Once the urgency of grand jury presentation no longer exists, though, it typically takes several months for Detectives to complete the criminal case notebook for distribution to IAD and others in the Bureau. Thus, although the grand jury returned a no true bill (decided not to indict the involved individuals) in October, 2006, IAD did not receive the case notebook until the end of December, 2006. PPB reports to us that this customary time gap has decreased in the nearly four years since this incident, so that IAD now receives the Detectives' notebook in a more timely fashion.

Recommendation: The Bureau should consider creating an internal policy that would set a realistic but certain deadline by which the Detectives' notebook must be presented to IAD. Divergences from such an internal policy should be based on good cause and only after obtaining written approval at the Assistant Chief level.

In this case, however, it may not have mattered how quickly IAD received the Detectives' investigatory materials, because personnel issues within IAD created another four month delay. It was reported to us that during the relevant time period in 2006 and 2007, IAD was staffed at significantly less than its usual strength and was operating with a vacancy in its lieutenant position due to a retirement. We were informed that PPB had pulled sergeants out of IAD to work other, mainly patrol, assignments to contend with a Bureau-wide staffing shortage. In February, 2007, PPB addressed this problem by filling IAD positions with civilians (mainly investigators retired from PPB or other law enforcement agencies), but the interim period and transition time left IAD short-staffed for the critical time during which the Chasse investigation should have been moving forward. We applaud the Bureau's decision to staff IAD with civilians, insulating IAD from the vagaries of future staffing crises. Another benefit of using retired PPB investigators to perform IAD investigations is that the Bureau benefits from having personnel experienced in Bureau processes and procedures yet those personnel, who are ineligible for further career advancement, are less likely to be affected by external influences than officers who are looking for promotional opportunities might be.

Recommendation: The Bureau should consider drafting internal policies recognizing the critical importance of a robust IAD function and ensuring that resources not be diverted away from this unit.

IAD investigators assigned to the Chasse case began conducting interviews in May, 2007, interviewing the Medical Examiner and the responding paramedics from AMR. They then learned in July, 2007, that the Multnomah County Attorney's office would not permit the Sheriff's deputies or other personnel involved in the incident to be interviewed until after the plaintiff's attorney had taken their depositions in the civil case. The reason provided for this refusal was that the County did not want additional statements to be obtained that might be used by the plaintiff's attorney. It was also asserted by the County that the deposition testimony would fully answer any remaining questions that IAD investigators had. At this point, the IAD case stalled. IAD investigators had planned to interview the deputies prior to interviewing the involved PPB officers, and, in consultation with their supervisors – including an Assistant Chief – decided to stay with this plan and wait until the depositions were completed. When the

depositions were postponed from September, 2007 to January, 2008, the PPB reconsidered its position, and investigators interviewed the two involved PPB officers in November and December, 2007. This was already over a year after the incident.

The plaintiffs' attorney took the depositions of the involved officers and deputies in January, 2008, and the Multnomah County attorney handling the case finally made the deputies available to be interviewed in April, 2008. Investigators conducted those two interviews in May, and completed the initial draft of their case in June, 2008. Following review by IAD supervisors and the IPR, the case was completed in July, 2008. See the timeline attached at the end of this Report for a complete view of the entire investigation and review process.

B. Quality of the Investigation

The IAD investigation consisted of nine interviews – the Medical Examiner (interviewed twice), the two AMR paramedics who responded to the NW 13th and NW Everett scene, the two involved PPB officers and one involved deputy, a deputy from MCDC, and one civilian witness. Investigators attempted to contact two other civilian witnesses, but the witnesses did not respond to interview requests.[7] They prepared a 47-page report summarizing their work and a PowerPoint presentation for the Use of Force Review Board.

Overall, we found the work done by IAD investigators to be very good. The interviews conducted were thoroughly probing and largely devoid of problematic leading questions. Importantly, the questioning by IAD investigators took a broad view of the incident, looking beyond the question of whether the officers' use of force was appropriate to the broader issues regarding officers' tactical decisions and adherence to policy both before and after the force incident. Investigators aggressively questioned the officer and deputy about the bases for their decision to contact Mr. Chasse and then to pursue him on foot and take him to the ground. They also thoroughly questioned the sergeant, officer, and deputy about their interaction with paramedics and the decision to transport Mr. Chasse to the jail rather than have the ambulance take him to the hospital. Again regarding transport decisions, they questioned the officers about

[7] As with other police agencies, IAD investigators do not have authority to compel civilian witnesses to be interviewed.

the information they received from nurses at MCDC and the decision to return Mr. Chasse to their radio car rather than calling for an ambulance. Investigators' attention to each of these issues in their interviews with the involved officers assisted the Use of Force Review Board members in having a complete picture of the officers' states of mind at each of these critical junctures.

Investigators also thoroughly interviewed the AMR paramedics about their assessment of Mr. Chasse and, as importantly, the information provided to them by officers at the scene. Information gained from the paramedics prompted investigators to re-interview the Medical Examiner so she could clarify her earlier opinions. Though Detectives had interviewed 14 civilian witnesses, IAD sought to re-interview the three that appeared to have the most detailed information about the incident. Two did not respond to attempts to reach them, and investigators traveled to Oakland, California to interview the third.[8] The amount of independent work conducted by IAD demonstrates clear recognition by the Bureau that IAD should no longer rely entirely on the investigative work of the Detectives and merely repackage that work for administrative purposes. It is important to note that it was not too long in PPB's past when the simple repackaging approach was standard operating procedure for critical incident investigations.

While the interviews conducted were fair and thorough, we did find important missing pieces in the investigation. First, IAD investigators should have interviewed each of the PPB officers who responded to the NW 13th and NW Everett scene, and in particular, those officers who assisted in restraining Mr. Chasse and carrying him to the patrol car. While Detectives had interviewed these officers, IAD had new information from the coroner regarding the possible effects of the way in which Mr. Chasse had been carried.

In addition, we found that IAD could have done more to investigate allegations by citizen witnesses that officers and/or paramedics had been laughing and joking at the scene. While IAD investigators did ask those interviewed about these allegations with little result, because they did

[8] We have been informed that PPB's authorization for IAD investigators to travel out of state to interview a civilian witness was unprecedented. We credit PPB for this commitment to fact gathering for purposes of the administrative process.

not interview all officers at the scene, we cannot conclude the investigation was as thorough as it should or could have been on this point. The same is true regarding an allegation that an unidentified officer told a bystander that Mr. Chasse was on drugs and had prior drug-related convictions. Though IAD investigators had information regarding the patrol car in which this officer was seated when he allegedly made those comments, they were instructed to complete their investigation before interviewing the officer to whom that vehicle was assigned. It is not clear whether this decision was the result of a rush to complete the investigation once the litigation-related delays had ended, a belief that further investigation on this point was likely to be fruitless, a lack of regard for the importance of the allegation, or a combination of the three.

It would have been important to know whether the information allegedly passed on to the witness about Mr. Chasse originated with the involved officer or deputy or was generated from some other source. The allegation, if established, could suggest that there was a conscious or unconscious attempt to taint civilian witnesses with inaccurate information about the arrestee. If it could be verified that these comments were made, while there could also be innocent explanations for how this information was passed on to a witness, it was potentially relevant to the credibility of the officer or deputy and could have been indicative of an after-the-fact attempt to justify their pursuit and arrest of Mr. Chasse.

IAD investigators also did not fully explore the short delay in getting Mr. Chasse into the jail while the involved officer and deputy completed paperwork in a parking lot across the street from the jail. As a result, it was unclear why the officers chose to leave Mr. Chasse in maximum restraints in the back seat of the patrol car rather than carry him into the jail immediately and fill out the paperwork at that time.

Investigators also did not interview the MCDC nurses who observed Mr. Chasse at the jail, and only interviewed one of the deputies assigned to the jail who encountered Mr. Chasse, though it is clear that numerous jail deputies and other personnel had contact with Mr. Chasse and conversations with the officer and deputy who brought him in. We cannot be too critical of IAD for these particular omissions, however, because it is apparent that Multnomah County, who would not allow the involved deputy to be interviewed until he had been deposed, may have placed even greater restrictions on IAD when it came to interviewing the jail personnel.

Nonetheless, in the interests of conducting an entirely complete investigation, investigators should have requested these interviews and documented any refusal from the County.

The most glaring deficiency in the IAD investigation, though, was the failure to do everything possible to enhance the audio portion of a video taken at MCDC that depicts the involved officer and deputy recounting or reenacting their confrontation on the street with Mr. Chasse. The audio in the original recording is mostly unintelligible, but during the course of litigation, the parties were able to have it enhanced to a point where you can fairly clearly hear the officer say he "tackled" Mr. Chasse, seeming to contradict his statements to IAD that he had pushed Mr. Chasse to the ground, particularly when taken together with the deputy's gestures indicating a wrap-around type of tackle. The audio was not enhanced, though, until the IAD investigation was complete and the Use of Force Review Board had met to vote on its recommendations to the Chief. [9]

At that point, IAD had to wait until the Detectives conducted a criminal investigation considering the truthfulness of the involved officer, then wait further until the District Attorney had opined on the allegation, and then had to reconsider the allegations regarding the officer's truthfulness for administrative purposes. The Chief decided to wait to act on the Board's recommendation until the supplemental investigation was completed to learn whether that additional information might alter the Board's original recommendations. In the end, the failure to recognize the potential importance of the video and act on it early caused the case to drag on for an additional 10 months. That failure, however, should not be attributed to line investigators. Rather, we have been informed that the decision to not work harder to enhance the audio portion of the video was made further up the chain of command. Though we were unable to get a consistent explanation from the numerous people we spoke to on this issue, two things seemed to have motivated that decision – cost and the sense that it was not too important a piece of evidence. Neither is an adequate explanation, given the gravity of this case and the central issue

[9] We were informed that some work to enhance the video had been attempted by PPB's own forensic unit early in the case, but that the results were unsatisfactory. To the degree this occurred, it was not sufficiently documented in the file and the end result in which the audio was considerably enhanced suggests that insufficient emphasis was placed on this evidence.

of the officer's credibility. It is unsettling that a private plaintiffs' attorney was the driving force behind PPB's ultimate recognition of the importance of the video as evidence.

In addition, even if technology to enhance the audio track was prohibitively expensive, the unenhanced video shows numerous jail personnel listening to and watching the officer and deputy tell their story. As noted above, PPB could have sought to interview these individuals prior to the close of the IAD case, but did not.

We also note that the missing pieces in the IAD investigation referenced here could have been recognized and possibly remedied by IPR in its oversight role. However, this observation must be considered in the context of the evolution of IPR's role in shaping critical incident investigations. Since 2006, that role has continued to enlarge, and while IPR did, in fact, offer helpful suggestions and input to IAD regarding some of the issues presented in the Chasse case, the input of IPR in critical incident investigations had not matured to the point where it is today.

C. Delays and Lessons Learned

As with the decision about enhancing the jail video, the other delays in the IAD investigation were mostly out of the control of the individual investigators. IAD staffing issues and decisions made around the inability to interview the involved MCSO deputy were broader Bureau concerns.

There are several lessons the Bureau can learn from this incident related to the challenges surrounding the delays stemming from the litigation. First, the PPB should make (and to some degree already has made) agreements with the other participating agencies in the Transit Police Division regarding their obligation to cooperate in PPB investigations. (See Section XIII. Transit Police Division Challenges, below).

Second, the Bureau should recognize the cost of delaying an investigation and consider how best to weigh those costs against competing factors. Here, the Bureau[10] decided first not to

[10] In recognition of the uniqueness of this case, decisions about who to interview and when were not made by investigators, but by their supervisors, at times all the way up to the Assistant Chief level.

conduct an interview of its own sergeant and officer until it could interview the involved deputy. This decision was later reversed and investigators were allowed to proceed with interviews prior to the deputy's participation, but not until more than a year had passed from the time of Mr. Chasse's death.

Ordinarily, best investigative practices dictate that the initial criminal interview of involved personnel or witnesses does not suffice for purposes of the administrative interview. Moreover, those practices suggest that investigators should proceed to interview involved persons in ascending order of the degree of involvement of each individual. Accordingly, it was sound investigative practice for IAD to devise a plan to interview the deputy first and then interview the PPB sergeant and officer.

That plan ran into a major snag, however, when the Assistant County Attorney announced that she was preventing the deputy from being interviewed until after he was deposed in the civil litigation, a delay that ended up being nearly a year. At this point, the Bureau was faced with various courses of action, none of which were ideal.

First, when initially encountering resistance by County authorities to the interview, PPB could have raised this issue with its Commissioner and/or the Council as a whole. The initial resistance by the County lawyer to have the deputy interviewed may have been overcome as a result of the involvement of the City's elected officials in discussions with their counterparts in County government. Such discussions might have better framed the issue of ensuring timely internal fact gathering for the benefit of the Bureau and the Portland community at large. Because this was not considered, we will never know whether such an approach and potential dialogue may have ended the logjam.

Recommendation: In critical incident investigations where outside government agencies place roadblocks on access to information or witnesses, PPB should consider enlisting the assistance of its Commissioner and/or City Council to help remove those roadblocks.

A second option available to PPB was to move forward with the IAD investigation without interviewing the involved deputy. Fortunately, Detectives had already extensively interviewed the deputy, and PPB had that interview available for purposes of the IAD

investigation. While there certainly were subjects relevant to an administrative investigation that were not directly broached by the criminal Detectives, PPB might have internally asked whether the potential additional information that would be obtained by a delayed IAD interview was worth the delay. This inquiry becomes particularly germane considering that by the time IAD was permitted by the County Attorney to interview the deputy, nearly two years had passed from the time of the incident and the deputy had spent numerous hours preparing for and then giving a deposition, calling into question how helpful and pure such an interview could be at that point.[11]

Recommendation: In critical incident investigations where outside entities successfully prevent timely access to important witnesses, PPB should consider the evidence already obtained from the witness, the potential value in obtaining delayed information from the witness(es) in question, and determine whether the IAD investigation should proceed without the additional information.

It is unfortunate that PPB was faced with this dilemma as a result of the County Attorney's hands-off position regarding IAD's access to the deputy, even after he became a PPB employee.[12] The County Attorney's position runs counter to progressive practices in defining the relationship between the need for internal fact gathering and the need to defend the government entity from civil litigation. For most progressive agencies, the balance is struck in favor of fact gathering rather than having the internal investigative process shut down and dictated by the pace of civil litigation. The County Attorney's focus on the County's fiscal interests delayed the Bureau's search for truth, hampered its ability to formulate a systemic

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[11] Strategic decisions and advice on how to answer questions posed during a deposition by plaintiff's counsel are not intended to produce and unvarnished and candid recitation of the witnesses' observations.

[12] We were informed that even after the deputy had left the MCSO and was working for the Bureau, the Assistant County Attorney suggested that were he to be interviewed before his deposition, any resulting judgment from the civil litigation might need to be paid from his own pocket. In a meeting involving executives at the Bureau's highest levels, the Bureau decided not to compel the former deputy to be interviewed and risk his exposure to that liability. As noted above, in retrospect, it probably would have been better for the Bureau to present this issue to the Police Commissioner or other elected officials for possible input and intervention.

response, and significantly slowed its decision making on individual accountability for its employees.

Most concerning is that such a perspective may be applied beyond this case to other witnesses in future incidents. As noted above, the County also did not allow one of its deputies working in the jail to be interviewed until he had been deposed. Other potential witnesses to the officer and deputy statements and actions in the jail were also not interviewed by IAD, probably because of the hands-off approach adopted by the County attorneys for the first two County witnesses that IAD wanted to interview. Accordingly, if this case can be seen as a prologue to future inaccessibility of County employees, it portends future hamstringing of PPB in-custody death investigations.

One way in which PPB could protect itself from a similar future stymie would be to develop an understanding that, in critical incident investigations in which non-PPB witnesses may have important information, criminal Detectives need to expand their initial questioning of these witnesses to include potential administrative issues. These issues are potentially relevant to the criminal investigation as well but are oftentimes reserved for the IAD investigators. Now that PPB knows that outside entities may place these witnesses outside the reach of its IAD investigation, it should move to ensure that its Detective personnel obtain the information as part of their criminal probe. Should outside government entities resist interview requests by the criminal detectives, those witnesses can be subpoenaed to testify before the grand jury. Homicide Detectives can then ensure that their testimony is recorded and retrieve a copy of the tape or transcript of the grand jury proceedings.

Recommendation: In shootings and in-custody deaths involving members of outside law enforcement agencies as either participants or witnesses, Detectives should be instructed and trained to question these individuals regarding administrative issues when they interview those outside members, on the assumption that IAD may not be able to timely interview them.

VI. Training Division Analysis and Recommendations

The Training Division reviews all officer involved shootings and in-custody deaths, summarizing each involved officer's training background and analyzing each aspect of the incident to reach a conclusion about whether each officer's actions were consistent with applicable training doctrines. Typically, the Training Division's analysis is prepared by a sergeant, but because of the gravity of the Chasse case, the Training Captain – with the Chief's concurrence – appointed a seasoned lieutenant to handle the review of this matter.

The Training Division review in the Chasse case is a 22-page document that analyzes in detail each of the decisions made by the involved sergeant, officer, and deputy as they encountered and apprehended Mr. Chasse. It examines the entire incident and describes the training each PPB officer receives relevant to each of the critical decision points. It concludes that two of the officer's decisions were inconsistent with the Training Division's Tactical Doctrine. First, it states the officer should have advised dispatch of the location and circumstances prior to contacting Mr. Chasse. Second, the Training analysis concludes that, even though the officer and deputy had reason to contact Mr. Chasse based on the belief he had urinated in public, initiating a foot pursuit and then knocking Mr. Chasse down was inconsistent with training because the officer did not adequately consider the severity of the alleged crime and the risk to public safety. The Training analysis also discusses the deputy's application of the Taser as being less than ideal but not improper, but declines to reach a conclusion based on the fact that the deputy was not, at that time, a PPB member.

Perhaps even more important than its analysis of the officer's performance is Training's identification of "lessons learned" to be disseminated to the Bureau in a meaningful and helpful way. The Training Division document in the Chasse case concludes with eight recommendations, all of which the Bureau has implemented:

- Provide the 40-hour Crisis Intervention Team ("CIT") training to all uniformed officers and sergeants.

- Revise emergency medical procedures to give greater direction to Bureau members in advising EMS personnel and deciding how to transport subjects. (Addressed in Directive 630.45, effective January 30, 2007)

- Provide additional in-service training regarding person encounters and the use of physical force.

- Update Advanced Academy Training to include CIT training and reinforce person encounters and applicable statutes and policies relating to foot pursuits.

- Develop and disseminate a roll-call video pertaining to foot pursuits, highlighting the dangers of pursuits and the knock-down technique.

- Develop and disseminate a roll call video discussing the proper application of the Taser at close quarters.

- Expand the Training Division's Foot Pursuit Tactical Doctrine to provide additional emphasis on the need to consider at the outset the severity of the crime, applicable statutes and policies, knowledge of the subject, including physical descriptors, and the immediate environment.

- Send members to the National Sudden Death and Excited Delirium Conference.

The document prepared by the Training Division is impressive in its detail and thoughtfulness. In relation to the work conducted by other comparable police agencies in identification of systemic issues, the product emanating from the Bureau is remarkable. For too many police departments, the identification of systemic issues coming out of critical incidents is, at best, uneven and idiosyncratic.

We are extremely impressed with the Bureau's willingness to quickly implement these recommendations without waiting for completion of the investigation or any orders deriving from the litigation. The Bureau's resolve to identify the multitude of systemic issues stemming from Mr. Chasse's death, develop remedial measures, and ensure timely implementation of those recommendations for reform is testament to PPB performing at its highest level. We have

reviewed many other critical incidents for comparable law enforcement agencies and the evidence of resolve by PPB executives to timely implement the recommended reforms is one of the most impressive that we have seen.

That being said, as we note elsewhere, there were two additional issues emanating from the Chasse incident that were not addressed by the Training analysis – the involved supervisors failure to relinquish command of the incident to another responding sergeant and officers' decision to carry Mr. Chasse to the patrol vehicle while in maximum restraints. This fact does not contradict our assessment of the Bureau's processes relative to other police agencies – we dare say that many similarly situated police agencies that do not possess the robustness of the Bureau's processes could well have neglected to identify and address even the eight recommendations that were identified.

One equipment issue that was not addressed by Training is whether the Bureau expects that breathing guards should be standard equipment in patrol cars and readily available to officers. As noted above, when Mr. Chasse began showing signs of distress, the deputy stopped the car and attempted to administer aid. The deputy attempted to locate a breathing guard in the trunk of the patrol car, but could not find one. While this lack of equipment likely did not have impact on the final tragic result, there was no discussion in the Training analysis about this equipment issue and how it might hamper officers' ability to provide first aid in future incidents. In our discussion of this issue with PPB executives, we were told that the Bureau now requires that each patrol car be outfitted with a breathing guard.

VII. Unit Commander's Review

When the IAD case and Training Analysis are complete, they are sent with the Detectives' notebook to the Commander of the involved officer(s) Responsibility Unit ("RU manager") for his or her review and findings. Here, the Commander who had been in charge of Transit at the time of Mr. Chasse's death concluded that all of the sergeant's and officer's actions in this incident were within policy. Her analysis tracked the incident chronologically and evaluated the foot pursuit and takedown, the use of force in restraining Mr. Chasse, the decision to put him in maximum restraints and take him to jail, and the decision to transport him from the jail to the hospital. The major emphasis of the Commander's four-and-a-half page analysis is on

the officer's decision to pursue and take Mr. Chasse to the ground. Most notably, it discusses the officer's legal right to stop and arrest or cite Mr. Chasse for indecent exposure in connection with the officer's belief that Mr. Chasse had urinated in public and his further belief that Mr. Chasse's odd behaviors were related to narcotics use. It cites the large number of complaints Transit Division receives regarding drug dealing on and around the transit system and the Division's proactive response in attempting to eradicate drug dealing and other nuisance behaviors.

As we discuss below (Section XIII. Transit Police Division Challenges), we heard from numerous sources that the Transit Division had a particular way of doing business that set it apart from the rest of the Bureau and seemed to give license to tactics not supported by Training or condoned in other divisions. We also heard that this was a direct response to community expectations and Transit Division's mission to eliminate drug sales and nuisance crimes from on and around the transit system. Aware that this would be an issue likely raised in the officer's defense, Bureau command staff responsible for IAD proposed expanding IAD's investigation to examine the role of supervisors and executives who may have been instructing or tacitly allowing Transit Division officers to in effect diverge from their training and Bureau policies in pursuit of their mission, but was instructed not to by supervisors up his chain of command.

In our experience, tactical decision making by individual officers in critical incidents often can be attributed to supervisory instruction that is at odds with agency practices. When evidence of this exists, it can often excuse the officer's performance in whole or in part. However, such evidence must be fully explored during the investigation so the agency can remedy the situation and, when appropriate, hold those supervisors accountable for poor direction. It is unfortunate that, in this case, IAD investigators apparently were directed away from pursuing this investigative strategy.

Recommendation: In cases where tactical decision making may have resulted from a lapse of supervision, the Bureau should encourage rather than limit IAD's development of these issues in its investigation.

Based on our discussions with Bureau executives, it appears this recommendation may already have begun to be addressed. The Bureau understands that supervision is an important

element of critical incidents and that facts regarding those supervisory issues must be collected in order for them to be assessed. We have learned that the Bureau has recently approved a new format for memos from the Review Board that automatically triggers the question of whether supervisory issues should be assessed, and we are hopeful this will serve as a signal to IAD that the Bureau intends for investigators to gather these facts so that the Board can conduct a robust review of these issues.

VIII. Use of Force Review Board

A. Chasse Review Board

In the Chasse case, the Use of Force Review Board ("UFRB") convened twice – first for two days on October 1 and 2, 2008, to discuss the initial question of whether the PPB sergeant and/or officer who, together with the MCSO deputy, first made contact with Mr. Chasse violated any PPB policies and to consider the systemic recommendations advanced by Training. The Board met again on September 16, 2009, to discuss whether evidence brought to light following the enhancement of the jail video in any way changed the Board's initial findings.

At the time, the UFRB was a 14-member Board (with eight voting and six non-voting members) that served as an advisory body to the Chief. The UFRB reviews officer-involved shootings, in-custody deaths, and certain other force cases and recommends to the Chief findings on whether or not the force used was within PPB policies. In addition, the Board may comment on the adequacy of the investigation and the Responsibility Unit manager's findings, ask for additional investigation, recommend action items, and consider performance issues. The board also reviews systemic recommendations put forward by Training Division and considers whether to recommend implementation of those reforms to the Chief.

The UFRB's first meeting in the Chasse case was an unusually long affair, 10 hours over two days. It first heard a joint presentation from Detectives who handled the homicide investigation and IAD investigators responsible for the administrative investigation. Training Division then presented its analysis. One issue arose during this Board meeting when the president of the officer's union (who regularly attends and is allowed to speak at meetings, but is not a Board member) questioned the Training Division Lieutenant about the apparent fact that a

well-respected Training officer disagreed with his finding that the decision to pursue Mr. Chasse was inconsistent with training. It is unclear how this exchange affected the Board's decision.

In the end, the UFRB determined the officer's actions throughout the incident to be within policy, but concluded the sergeant had violated the Bureau's policy regarding medical treatment for subjects following application of the Taser (Directive 1051.00) and recommended that all three involved members be debriefed on this issue. On the question of whether the foot pursuit of Mr. Chasse was within policy, there was only one dissenting voting member who believed, consistent with the Training analysis, that the officer did not adequately consider the safety of the officers, public, or Mr. Chasse in deciding to initiate the pursuit. The opinion conveyed in the memo from the Transit Division Commander – that discipline for the officer's decision to pursue would be inappropriate because the officer was taking the kind of proactive, aggressive police action his supervisors at Transit encouraged – apparently trumped the Training Division analysis and carried the day with the Board. Several Board members and others in the Bureau with knowledge of the case acknowledged that the Board was reluctant to recommend discipline for the involved officer for initiating the foot pursuit and taking Mr. Chasse to the ground because he was acting in accordance with Transit's mission to eradicate drug dealing and other nuisance behaviors on and around the trains, even if it was contrary to the Bureau's training expectations. (See Section XIII. Transit Police Division Challenges, below).

The Chasse UFRB reconvened in September, 2009 to vote on whether the additional investigation surrounding the enhancement of the jail video caused members to change their initial votes. IAD did a brief presentation and the Board viewed the enhanced jail video a number of times. Notably absent from the supplemental review, though, was a revised Training Division Analysis. The initial Training analysis assumed as true the officer's statement that he used the "knock down technique" taught by Training as a preferred way of terminating foot pursuits. The new evidence suggested that the officer tackled Mr. Chasse in more of a "bear hug" fashion, an approach that presumably was inconsistent with Training. The reconvened Board did not hear any opinion from Training regarding the impact of the additional investigation on its analysis.

When votes were tallied, a near-unanimous Board determined that nothing in the additional investigation should change the original recommendation. There was, unfortunately, significant confusion regarding this unprecedented process. Some Board members reported they had no clear sense of direction as to why they were there a second time or what their role was supposed to be. They did not have access to the supplemental IAD investigation prior to the meeting, as even the Board's organizers seemed uncertain as to the appropriate way to handle this supplemental or secondary review. Moreover, as reported above, no supplemental training analysis was prepared or presented to the Board. Based on our interviews and document review, there appears to have been a strong feeling that the Bureau needed to quickly resolve this supplemental issue so that it could put this case behind them and move on.

Recommendation: The Bureau should consider modifying Use of Force Review Board protocols so that in cases in which new evidence is developed and considered by the Use of Force Review Board, the Training Division should be contacted to determine whether a supplemental analysis and presentation to the Board is warranted.

B. Use of Force Review Board Structural Issues

Passage of a new Police Review Board ordinance this spring (City Code and Charter Chapter 3.20.140), coupled with a new Police Chief, provides the Bureau the opportunity to refine and redefine the UFRB. The biggest change is to the composition of the Board, which will now have seven voting members and nine advisory members, and will be chaired by a Review Board Facilitator who is not a member of the Board. The IPR Director, previously a non-voting member, now has a vote.

As noted in PARC's Second Follow-Up Report (December 2006), the Bureau has adopted many of the recommendations for the UFRB from prior PARC reports in Bureau Directive 335.00. The new ordinance reinforces those improvements over prior review processes, and codifies some important changes, such as the requirement that the Board prepare a detailed statement of its recommended findings and proposed discipline, including a record of its vote, an explanation of its rationale, and details of any minority position.

One PARC recommendation from the December 2006 report that has not been implemented called for a procedure for notifying all UFRB members of the final outcomes of the cases in which they participate. We support this recommendation. Failure to inform members of final outcomes demonstrates a lack of appreciation especially for the citizen volunteers' time and efforts and represents a missed learning opportunity in those cases where the Chief and/or Commissioner diverge from the Board's recommendation. For cases that proceed to arbitration, the final decision and any resulting analysis would inform Board members on how any recommendations were considered by an outside entity. Finally, demonstrative evidence of the Bureau's implementation of any training or policy recommendations proposed by the Board would demonstrate how the Board can be an effective change agent for the Bureau.

Recommendation: The Bureau should consider revising its protocols so that all UFRB members are notified of the final outcomes of the cases in which they participate.

During our review, we also learned of a concern over the availability of investigative materials during Board meetings. Citizen and peer members of the Board do not receive copies of the investigation, but are required to review the materials in the Chief's office in the weeks prior to the UFRB. During the Board meetings, the Assistant Chiefs have copies of the materials available for review during the meeting. In the past, if a citizen or peer member wanted to reference something from the investigation, he or she had to borrow an Assistant Chief's book. We were pleased to be informed that this has very recently changed, and the Bureau now makes additional copies of the investigative materials available so that all Board members can readily access a given transcript or diagram during the meeting.

Finally, we question the Bureau's preference for having involved officers attend the UFRB. Board members reportedly find it helpful to hear an account directly from the officer.[13] Throughout our review, we heard from several about the value of having officers attend Board meetings and the disappointment over the more recent trend of officers declining the invitation,

[13] One way to ameliorate some Board members' concerns that simply reading a transcript of the officers' interviews is overly sterile would be to make the interview tapes available for listening prior to the convening of the Board.

as they did in the Chasse case. Indeed, we learned that Bureau executives made significant efforts to have the involved officer appear before the UFRB in this case.

Though we have never attended a UFRB meeting and our experience with PPB is limited to review of this case, we are concerned about the Board's eagerness to question or take statements from involved officers. In our view, the officers' statements or response to questions are just as likely to muddy as to clarify the facts. During both the criminal and IAD investigations, the officer is given the opportunity to present any pertinent facts when he or she is interviewed. Sometimes an officer who has had the opportunity to review the case files following his or her interview can clarify matters that were not obvious to him or her at the time of the interview and the system does allow for this, with the opportunity to schedule a mitigation meeting with the Chief after the issuance of the UFRB recommendations. But from what we have heard, officers who attend UFRB meetings are most likely to put forward an emotional rather than factual appeal, and those who have clearly violated policy but do not accept responsibility and plead for a merciful recommendation are judged harshly. Of course, others emotionally impacted by the critical incident – family members of the decedent, advocates, or citizen witnesses – do not have the opportunity to similarly address the Board in person. If the Board is intended to be a dispassionate fact finding body, the necessarily emotion-laced impact that results when involved personnel appear before the Bureau-dominated Board seems to run contrary to that intent.

Recommendation: The Bureau should reconsider the advisability of encouraging an involved officer to appear before the UFRB. At a minimum, if officers do continue to sometimes attend UFRB meetings, the Bureau should consider requiring the facilitator to prevent emotional appeals and ensure that officers and Board members limit the discussion to factual issues.

IX. The Bureau's Corrective Actions

Following Mr. Chasse's death, the Bureau took initiative in implementing a number of new policies, practices, and training protocols to address some of the issues raised by this incident. We applaud the Bureau's initiative and offer a few suggestions for improvement.

A. Policies

1. Emergency Medical Custody Transport Directive

Most immediately, in January, 2007, the Bureau implemented a new policy regarding the transport of injured or ill subjects. It provides clearer guidance to officers confronting decisions about when to transport subjects to jail and when ambulance transport to the hospital is required, both at the scene and at MCDC booking. The policy places on EMS personnel at the scene the responsibility for determining whether an in-custody subject requires ambulance transport to a hospital or can be transported to jail by officers. Addressing two concerns about the events surrounding Mr. Chasse's treatment, it also clearly requires officers to provide EMS personnel complete and thorough information regarding any force used against the subject, and prohibits officers from signing medical transport refusal forms on behalf of subjects.

The policy also states that EMS will provide officers with a copy of the Pre-hospital Medical Treatment Worksheet whenever the subject is to be transported to jail. Officers are required to provide the Worksheet to medical staff at MCDC. If medical staff refuses to admit a subject, the medical official is supposed to document that refusal and determine the appropriate mode of transport. If the medical staff refuses to admit a subject and determines that the subject can be transported via patrol vehicle, the officer is to document the refusal and notify a sergeant.

In general, the Medical Transport policy is an extremely positive effort toward providing clarity in challenging situations, and we applaud the Bureau for quickly addressing the issues so clearly raised by Mr. Chasse's death. However, we did find some of the language to be a bit unclear and unenforceable. In particular, the policy purports to require EMS personnel and MCDC medical staff to provide documentation, but those individuals are neither trained in nor bound by PPB policies. The policy would do better to require PPB officers to request the documentation and notify a sergeant of any refusal. In addition, the policy does not squarely address the precise situation the involved officer and sergeant confronted here – where EMS personnel cleared Mr. Chasse for transport to the jail while at the same time offering to transport him to the hospital, leaving it up to the involved sergeant to determine what would be best for

Mr. Chasse.[14] Ideally, EMS personnel would make that decision. Where they refuse, the best policy would either default to requiring EMS transport or, at a minimum, require the responding sergeant to document the information he or she provided to EMS and articulate the reasons for permitting officers to transport.

Recommendation: The Bureau should consider refinements to the Emergency Medical Custody Transport Directive to more clearly define PPB officers' responsibilities.

2. Revised Use of Force Policy

Two months following Mr. Chasse's death, the IPR and PPB convened a Task Force to study, report on, and make recommendations regarding the use of force by PPB members. We have been informed the Force Task Force was not convened in direct response to the Chasse incident but had been planned in response to earlier troubling incidents. Nonetheless, to the extent this case contributed at all to the urgency or content of the discussion, the Bureau should be credited for moving forward in a positive way. The Task Force made a series of recommendations that ultimately resulted in a revised Physical Force policy (Directive 1010.20) in March 2008. The policy is laudable for a number of provisions, including its main requirement that members use only that force "reasonably necessary under the totality of the circumstances to perform their duties and resolve confrontations effectively and safely" even when higher levels of force may be legally allowable. The Task Force was reconvened in 2009 and found the Bureau had implemented all of the recommendations emanating from the earlier report.

3. Foot Pursuit Policy

Two months prior to Mr. Chasse's death, the Chief issued an Executive Order regarding foot pursuits (published in January, 2007 as Directive 630.15). The Directive is an excellent policy statement on the dangers of foot pursuits and contains a number of cautions and prohibitions designed to promote officer safety. The policy was borne out of PARC

[14] We have concerns about the involved sergeant stepping into the role of incident commander and coordinating the EMS response after having been directly involved in the force incident. (See Section X. Supervisory Issues, below).

recommendations and a concern about the frequency with which officer involved shootings are preceded by foot pursuits. The policy talks generally about the officer's need to be aware of the degree of risk to which the officer exposes himself or herself and others, then speaks specifically to factors dealing with armed suspects and the tactics officers should employ when pursuing suspects. Among the factors to be considered when initiating/continuing a foot pursuit, it does not enumerate those factors which would have been most relevant to the decision to pursue Mr. Chasse – the severity of the crime for which the suspect is being pursued, applicable statutes and policies, and the benefit of the suspect's capture. The Training Division has expanded its Tactical Doctrine to include these factors.

Recommendation: Consistent with its revised Tactical Doctrine, the Bureau should consider revising its foot pursuit policy to include additional factors officers should weigh in deciding whether to initiate or continue a foot pursuit.

4. Mobile Crisis Unit

In April, 2010, the PPB's Operations Branch, working with Project Respond, established a Mobile Crisis Unit that teams a Project Respond mental health clinician with a PPB officer. Their objectives are to respond to service calls involving individuals in a mental health crisis, provide follow-up on referrals from field officers or Project Respond clinicians, provide on-scene mental health consultation and assessment in critical incidents, and conduct proactive investigations involving transient persons who appear to be suffering from a mental illness with the goal of directing them to services. The unit operates only within the Central Precinct and its operating procedures are intended to cover a one-year trial period after which the program will be analyzed to assess whether it should be made permanent. It is certainly too soon to say whether this program will be effective, but the Bureau deserves praise for its willingness to work with the mental health community in an effort to find creative solutions to a sometimes seemingly intractable problem.

B. Training

1. CIT Training

Perhaps the most impressive response the Bureau made to the Chasse incident was its commitment to provide the 40-hour Crisis Intervention Team (CIT) training to all of its uniformed officers and sergeants. To complete such extensive training of nearly 1,000 members within 15 months of this incident was a remarkable accomplishment of which the Bureau should be proud.

We have been informed that there has been reluctance by the Bureau to open this training to non-Bureau members because to do so could chill participants' willingness to share personal experiences. While we understand that outside observers can inhibit candid dialogue, we wonder whether at least some of the class could be opened up to the public without undercutting its value to the participants.

Recommendation: In the interest of transparency, the Bureau should consider whether a portion of its CIT training could occasionally be opened and training materials made available to interested members of the public.

2. Videos, Bulletins, and In-Service Training

In response to the Chasse case, the Training Division targeted subsequent in-service training on use of force issues, updated its Advanced Academy Training to regularly feature scenarios, including CIT-related problems, and produced a number of videos and briefings. As part of our analysis, we reviewed a number of roll-call videos, "Tips and Techniques" briefings, and course materials relevant to the Chasse case, including: Foot Pursuits, highlighting the dangers of foot pursuits and the knock-down technique; Taser use in close quarters with a violently struggling individual; Hobble Review/Excited Delirium, instructing officers on the carry and transport of subjects in maximum restraints; and Emergency Medical Transport Directive. We found these materials, particularly the videos, to be of very high quality.

We noted that the Bureau has in the past used specific incidents as the basis for training videos, including one video we reviewed that discussed the problems associated with another in-

custody death. While we recognize the emotions surrounding the Chasse case may make it difficult for the Bureau to consider using it in training materials, utilizing the whole event as a learning tool may prove invaluable, not just to the officers who receive the training, but to the entire Bureau, as a signal it has learned from the challenges presented in this case.

Recommendation: The Bureau should consider whether the circumstances surrounding the Chasse case can be developed into a training video for the benefit of all Bureau members.

C. Foot Pursuit Data Collection and Tracking

Following the first Use of Force Review Board in October, 2007, the Chief directed the Office of Accountability and Professional Standards to begin tracking foot pursuit data, including when, why, how often, and with what results officers chase suspects. It is our understanding that this project is ongoing, but moving slowly because of the need to change the data collection forms to gather the relevant information. With the recent restructuring of OAPS under the new Chief, the status of this project is unclear. We recommend the Bureau continue this project to give its managers a clearer picture of where and under what circumstances officers engage in the most high-risk foot pursuits. In the interests of transparency, the Bureau should share this data with the public as it becomes available.

Recommendation: The foot pursuit data collection and tracking initiative should continue to be supported by the Bureau and the data developed from the initiative should be periodically made available to the public.

X. Supervisory Issues

The sergeant involved in the force incident assumed a role as incident commander once Mr. Chasse was restrained, taking responsibility for coordinating the responses of other units, speaking with concerned members of the public, communicating with responding EMS personnel, and identifying and interviewing witnesses. While not prohibited by any policy or specific training, common sense should have dictated that another supervisor assume responsibility for these tasks. Indeed, another sergeant did respond to the scene, but reported that the involved sergeant was at the scene and seemed to be in control. The second sergeant assisted

with getting Mr. Chasse into the patrol car and then left the involved sergeant at the scene to contact witnesses and coordinate any further response. No doubt the involved sergeant had been affected by the struggle with Mr. Chasse and the fact that he had been bitten on the leg. His adrenaline was likely elevated, and he may have been physically impacted and almost certainly emotionally tied to the outcome in a way that the uninvolved sergeant would not have been. Ideally, the involved sergeant, along with the officer and deputy, should have reported their uses of force to the responding sergeant, who should have assumed command of the incident and, in particular, communicated with paramedics and made the decision about whether to transport Mr. Chasse to jail or send him to the hospital via ambulance.

This issue, though identified by some in the Bureau, was not raised in the Training Division analysis, nor has it been addressed by subsequent corrective actions.

Recommendation: The Bureau should consider devising a Directive requiring any sergeant or lieutenant involved in a significant use of force incident to relinquish his or her role as supervisor once the force incident is over and to call for another supervisor to respond to the scene and assume command of the response to the incident. Any supervisor who responds to an incident in which another supervisor has been involved also should have a concomitant duty to assume command and relieve the involved sergeant or lieutenant of his or her on-scene responsibilities.

XI. The Decision to Carry Mr. Chasse to the Patrol Vehicle

Once the sergeant made the decision to have Mr. Chasse transported to jail, he and three other officers carried Mr. Chasse in the maximum restraint position back to the officer and deputy's patrol car, a distance of approximately 30 – 40 feet. They carried him face-down, with one officer at each of his armpits and one officer at each leg. The officers describe that during the carry Mr. Chasse was struggling and pulling against the restraints. The officers placed Mr. Chasse into the patrol car and transported him to the jail. He was still in maximum restraints, so he was strapped into the backseat of the vehicle, lying on his side. At the jail, the officer and jail deputies carried him in the same manner into a cell.

The Medical Examiner opined that the manner in which Mr. Chasse was carried may have exacerbated his rib fractures, displacing them and causing his punctured lung. As evidenced by the Medical Examiner's opinion, carrying a struggling individual by his extremities places inordinate strain on the body. It is puzzling in this case why officers decided to carry a struggling Mr. Chasse the entire distance of the pursuit, when it would have been easier to drive a patrol car closer to the location where he was brought into custody. The Medical Examiner's opinion should have caused IAD to focus on this issue as critical, but, unfortunately, the manner in which Mr. Chasse was carried was not fully explored by investigators, who did not interview all of the Bureau officers involved in carrying Mr. Chasse.

This lack of focus on this part of the episode carried over to the Training Division analysis.[15] In particular, there was no discussion in the analysis about whether it would have been preferable to shorten the distance in which the struggling Mr. Chasse was carried to minimize the likelihood that his injuries would be exacerbated. In addition, there was no discussion in the analysis about whether alternative approaches should have been devised regarding the manner in which he was carried. As a result, the Use of Force Review Board offered no recommendations regarding systemic reform of this aspect of the encounter.

If a person must be moved while in maximum restraints, best practice is to let medical personnel transport, so the person can be placed on a gurney to fully support his or her body weight and then monitored by medical personnel. At a minimum, best practices dictate that subjects not be transported in patrol vehicles in maximum restraints, but should have the maximum restraint removed and the hobble secured to the vehicle so that the individual's legs are still restrained but he or she can sit upright. If subjects must be carried, officers should minimize the distance they need to be carried.

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[15] This is understandable, in part, because the Training Division analysis in this case was completed before the IAD investigation, so it is possible that Training did not even know about the Medical Examiner's opinion on this point prior to preparing its analysis.

Recommendation: The Bureau should consider revising its policies and training to prohibit officers' transport of subjects in maximum restraints. It should also review its policy and training on carrying subjects in maximum restraints, explore alternative methods for moving subjects, and modify its training doctrines accordingly so that officers are at least instructed to minimize the distance they carry subjects in maximum restraints.

XII. Personnel Issues

A. PPB Hiring of Involved Deputy

While the IAD investigation was still pending, the Bureau hired the involved deputy to be a PPB officer. His application for a lateral move from the MCSO was pending at the time of the incident and moved forward despite his involvement. This decision was not made unknowingly or by accident, but was a deliberate decision made at the Bureau's highest level. Regardless of how attractive a candidate the deputy may have been, it is not a preferred practice to hire someone who is the subject[16] of a pending administrative investigation. To do so suggests that the Bureau had foreordained the outcome of the IAD investigation, at least with regard to the performance of the deputy.

Recommendation: The Bureau should consider adopting a policy of not hiring lateral candidates from other law enforcement agencies while they are the subjects of pending administrative investigations.

B. Assignment/Status of Officers during Pending Investigation

Following the Grand Jury, the involved officer returned to a Transit Division assignment. He was involved subsequently in another use of force that, while controversial on its own, became even more so as a result of his involvement in the Chasse case.

Mainly in response to recent officer-involved shootings, the Bureau recently implemented a policy requiring that members directly involved in fatal shootings be placed in

[16] The deputy was technically not a subject of IAD's investigation, but only because he was not a member of PPB at the time of the incident. MCSO did not conduct its own administrative investigation regarding the deputy's actions.

administrative assignments for at least one month following the Grand Jury, subject to month-to-month review by the member's division commander and Assistant Chief. This policy is advantageous in that it first treats all involved members the same and then allows for individualized treatment. Most importantly, it provides Bureau members prior guidance and expectations regarding how they are going to be deployed following a deadly force event.

Recommendation: The Bureau should consider extending this administrative assignment policy to officers involved in in-custody deaths.

XIII. Transit Police Division Challenges

The Transit Police Division is a multi-jurisdictional division under the command of the PPB responsible for providing police services on and around the rail and bus lines of the Tri-County Metropolitan Transportation District ("TriMet"). During our review, we heard from many sources that at the time of the Chasse incident, the Transit Division may have been operating under a different set of standards than the rest of PPB. There also was a belief that Transit had a unique mission in responding to the public's complaints about drug dealing and other nuisance behaviors on and around the transit system. For example, we learned that IPR was concerned even before the Chasse incident about the number of complaints it had received from people regarding the frequency with which Transit officers chased people and pushed them down.

In explaining the germination of the Transit Division culture, people reported an emphasis at the Division on addressing drug use and sales, as well as other nuisance issues, on and around the trains. Second, there was apparent concern that protracted foot pursuits and struggles with suspects near train lines would be dangerous because of the heightened risk of death should someone be on the tracks when a train came by. As a result, officers frequently chased suspects for minor crimes and attempted to very quickly shove them to the ground using the knock down technique.

Finally, it was expressed to us that at the time of the Chasse incident, Transit Division command staff largely allowed officers and first line supervisors in the field to develop their own priorities and ways of doing business. As a result, questions were raised about how effectively

the Transit Division command was ensuring that its officers' mission was consistent with both the Division and Bureau's mission. This phenomenon may have further widened the gap between Bureau expectations and Transit-specific practice and, as discussed elsewhere in this Report, the circumstance described was eventually used in the Chasse case as a defense and justification for the involved officer's decision making and tactical performance. Following the Chasse case, PPB reportedly dealt with these issues through changes in leadership at the Transit Division. We have been told that recent data suggests the Division is currently more in line with PPB expectations.

If, in fact, the Bureau has since 2006 effectively closed the gap between Bureau expectations and Transit-specific practice, there still remain challenges as a result of its current makeup that are deserving of further consideration. Transit is a multi-jurisdictional division, currently with officers and deputies from 14 other local law enforcement agencies working with the PPB under the authority of a PPB Commander. The multi-agency nature of Transit presents a number of challenges for the Bureau. The first is public confusion. Particularly in downtown Portland, where the most Transit activity occurs, citizens assume that Transit officers are PPB officers and assign blame to the Bureau when they have complaints, even though the reality is that there are nearly twice as many Transit officers from other agencies as there are from the PPB.[17]

More troubling issues relate to differences in the ways participating agencies hold their officers accountable. The Intergovernmental Agreements ("IGA") between TriMet, the City of Portland, and participating agencies provide that citizen complaints will be routed to the subject officer's agency and require each agency to maintain an accountability system through which those complaints will be investigated and evaluated. The agreements call for agencies to conduct joint investigations "when necessary and appropriate." Though we were told by PPB executives that there now exists an understanding that some participating agencies will permit PPB to handle administrative investigations, there is no formal agreement. The IGA we reviewed contains no specific provision even requiring the other agency to participate or cooperate in a

[17] Currently, of 45 Transit officers, only 16 are PPB employees; and of 13 supervisors (sergeants and lieutenants), five are from PPB.

PPB investigation, and no requirement that another agency conduct an investigation in a particular type of case (shootings or in-custody deaths, for example), let alone have its officers cooperate in a PPB investigation.

The Chasse case presents an example of the problems created when two officers from different agencies are involved in a critical incident. Multnomah County's litigation concerns hamstrung the PPB IAD investigation, while at the same time, because MCSO chose not to conduct a formal Internal Affairs investigation of its own, the deputy's performance was never reviewed to determine whether there were any violations of policy or training issues. In the Chasse case, the deputy did not play as significant a role as the PPB officer or sergeant, but it is not difficult to imagine a scenario where two officers from different agencies are equally culpable for some type of violation of policy or a poor tactical decision but only one is held to account.

Recommendation: The Bureau should consider initiating a dialogue with TriMet and participating agencies to forge an agreement that participating agencies will ensure complete and timely cooperation of their personnel, including an agreement to be promptly interviewed in any subsequent PPB criminal or Internal Affairs Division investigation. Any agreement should include specific language that ongoing civil litigation should not be a reason for refusing to provide PPB timely access to these individuals.

Inconsistencies in training and policy matters complicate PPB's ability to hold Transit officers accountable and more importantly, to ensure a coordinated and uniform tactical response to a dynamic unfolding event such as the Chasse incident. Each non-PPB officer is trained according to his or her agency's policies and procedures.[18] Without reviewing the manuals of each participating agency, we can guarantee that there are significant differences between those policies and those of PPB, whether regarding what force is reportable, how to conduct high-risk stops, or what each agency's expectations are regarding whether and how to go into foot pursuit. Accordingly, when a PPB officer is paired with an officer from another agency, there may well

[18] All Transit Police Division officers do receive PPB in-service training, but this is presented as a sort of refresher course training and does not expose officers from other jurisdictions to PPB tactical high risk training and protocols in a systematic, comprehensive way.

be uncertainty about which agencies' "playbook" is being used. Because the two officers are working off of different training experiences and different manual provisions, they may well have a divergent perspective on how to respond to emergent situations such as the Chasse case. For example, a PPB officer may be trained to use greater caution and be required to communicate with dispatch before going into a foot pursuit, while an officer from a participating agency may not operate under such expectations. When a Portland officer points his or her gun at someone, he or she must report that as a force incident; other participating agencies do not have such a reporting requirement. The fact that Transit officers are differently trained and work under divergent policy expectations presents the real potential that those officers will react differently and not complementarily in their approach to dynamic situations.

Labor agreements and practical realities likely make it infeasible for participating agencies to agree to require their officers assigned to Transit to be subject to all of PPB's policies and be part of PPB's complete training regimen. (The PBB Manual of Policy and Procedure is a 589-page book.) However, PPB could isolate key operational and tactical policies and training doctrines that all Transit officers could then be expected to follow. The Bureau could develop a focused training program to provide new Transit officers an understanding of these core policies.

Recommendation: The Bureau should consider the potential challenges, coordination, and uniformity issues presented by the multi-jurisdictional nature of the Transit Division and work with its counterparts to ensure all Transit officers have been trained in and will be held accountable to a set of core policies and key tactical training doctrines to better ensure that when officers are presented with dynamic events, there is a pre-existing, coordinated, and consistent understanding of how each participant will respond to that event.

XIV. Transparency

In our meetings with community members, we heard questions about IPR's role in officer involved shooting and in-custody death investigations. In this case in particular, some community members were frustrated by the slow pace of the investigation and their inability to learn from the Bureau how the investigation was proceeding. Indeed, the Bureau's reputation suffered from the public's reliance on the media for information about the case. While the Chief did issue press releases containing detailed information, including a four-page "Fact Sheet" in

October, 2006, immediately following the Grand Jury's no true bill, some members of the Portland community apparently reacted with skepticism to the information issuing from the Bureau.

IPR's ability to report to the public details regarding the investigation into Mr. Chasse's death certainly was limited during the pendency of that investigation, but it may have been able to report on its role in the investigation and subsequent UFRB and offer its assurance either that the investigation and review would be fair and thorough or that IPR would, at some point, inform the public of shortcomings. Indeed, the citizens we spoke with remain confused about IPR's role in this case. Part of this confusion stems from IPR's changed and enlarged role in reviewing critical incident cases. Certainly, in practice IPR's role in 2006 with regard to critical incidents was not the same as it is now. And its role continues to grow and shift with enactment of new Police Review Board and Independent Police Review Division ordinances (City Code & Charter 3.20.140 and 3.21) effective April, 2010. To the extent possible given the limits of its statutory authority and confidentiality obligations, IPR should try to increase public trust by disseminating information regarding the status of investigations and its role in attempting to ensure that the investigation will be fair and thorough and that the Bureau will reach principled decisions. Such information from the perspective of an independent entity would go a long way toward retaining the public's trust in the integrity of the process. In addition, IPR's response to the scene of critical incidents will also bolster the public's confidence in IPR's ability to effectively oversee the Bureau's investigations of these incidents.

Recommendation: IPR should consider whether it is appropriate to establish a more visible presence during the pendency of critical incident investigations to assure the public that an independent entity will be helping to shape the investigation and participating in the review to ensure thorough, fair and principled fact gathering and outcomes.

The City has a long and admirable tradition of seeking outside review of critical incidents. Members of the Bureau with whom we spoke expressed widespread appreciation for the value of independent review of these incidents. However, the practice has traditionally included long delays waiting for the conclusion of civil litigation before initiating outside review. In our view, this has greatly diminished its potential benefits. We support the City Auditor's

decision to initiate the review of the Chasse incident prior to the conclusion of the litigation, and hope she continues that practice going forward.

Recommendation: Outside review of critical incidents should not be dictated by the pace of any resulting litigation.

Investigation and Review Timeline

September 17, 2006	Mr. Chasse's death
October 2006	Grand Jury convenes; returns no true bill
December 2006	Meeting with Detectives, IAD, and Training to discuss case
January 2007	IAD and Training receive Detectives' notebook
May 2007	IAD begins conducting interviews
July 2007	Multnomah County Counsel advises IAD that MCSO deputy assigned to jail could not be interviewed until after depositions in September
September 2007	Multnomah County Counsel advises IAD that depositions postponed until January 2008 and that involved MCSO deputy and deputy assigned to jail could not be interviewed until after depositions; PPB executives decide to put IAD investigation on hold pending interviews of MCSO deputies
October 2007	Training Analysis completed; PPB executives reverse course and advise IAD to proceed with investigation
November 2007 - December 2007	IAD interviews involved PPB sergeant, civilian witness, and involved PPB officer
April 2008	Multnomah County Counsel authorizes interviews of MCSO deputies
May 2008	IAD interviews MCSO deputy and former deputy
June 2008	IAD investigation completed
July 2008	IAD revises case following input from IPR
August 2008	Transit Bureau Commander findings completed
September 2008	Assistant Chief findings completed
October 2008	Use of Force Review Board meeting
November 2008	Chief's memo adopting Training recommendations and delaying disciplinary decision until additional allegations regarding officer's truthfulness resolved
May 2009	Detectives' investigation completed; DA declination regarding perjury/untruthfulness allegation
June 2009	IAD case regarding untruthfulness allegation completed
August 2009	Transit Bureau Commander findings regarding untruthfulness allegation
September 2009	Second UFRB meets; Chief issues press release announcing UFRB findings and suspension of involved sergeant
November 2009	Police Commissioner issues press release announcing decision that both sergeant and involved officer would be suspended

OIR Group's Recommendations Based on the Review of the Closed Investigations of the In-Custody Death of James Chasse (July 2010)

Homicide Detectives' Investigation

Recommendation 1: The Bureau should consider adopting internal protocols for in-custody death investigations that recognize the advantage of on-scene face-to-face interviews for civilian eyewitnesses and the need to conduct those interviews shortly after the incident has occurred if practicable. If conducting such interviews immediately after the event is not practicable, that fact should be noted in the investigative file.

Recommendation 2: The Bureau should consider initiating discussions with the union to reform protocols so that involved personnel can be interviewed about their actions contemporaneous with the incident.

Recommendation 3: The Bureau should consider revising internal investigative protocols so that the transport of officers from the scene is documented.

Recommendation 4: The Bureau and the City should consider initiating dialogue with AMR to develop protocols ensuring future cooperation of the private ambulance company in PPB in-custody death investigations.

Recommendation 5: The Bureau should consider revisiting the idea of having IAD representatives respond to in-custody death scenes. The Bureau should continue to work with IPR to develop protocols so that IPR can become a regular part of the response to in-custody death scenes.

Internal Affairs Division Investigation

Recommendation 6: The Bureau should consider creating an internal policy that would set a realistic but certain deadline by which the Detectives' notebook must be presented to IAD. Divergences from such an internal policy should be based on good cause and only after obtaining written approval at the Assistant Chief level.

Recommendation 7: The Bureau should consider drafting internal policies recognizing the critical importance of a robust IAD function and ensuring that resources not be diverted away from this unit.

Recommendation 8: In critical incident investigations where outside government agencies place roadblocks on access to information or witnesses, PPB should consider enlisting the assistance of its Commissioner and/or City Council to help remove those roadblocks.

Recommendation 9: In critical incident investigations where outside entities successfully prevent timely access to important witnesses, PPB should consider the evidence already obtained from the witness, the potential value in obtaining delayed information from the witness(es) in question, and determine whether the IAD investigation should proceed without the additional information.

Recommendation 10: In shootings and in-custody deaths involving members of outside law enforcement agencies as either participants or witnesses, Detectives should be instructed and trained to question these individuals regarding administrative issues when they interview those outside members, on the assumption that IAD may not be able to timely interview them.

Unit Commander's Review

Recommendation 11: In cases where tactical decision making may have resulted from a lapse of supervision, the Bureau should encourage rather than limit IAD's development of these issues in its investigation.

Use of Force Review Board

Recommendation 12: The Bureau should consider modifying Use of Force Review Board protocols so that in cases in which new evidence is developed and considered by the Use of Force Review Board, the Training Division should be contacted to determine whether a supplemental analysis and presentation to the Board is warranted.

Recommendation 13: The Bureau should consider revising its protocols so that all UFRB members are notified of the final outcomes of the cases in which they participate.

Recommendation 14: The Bureau should reconsider the advisability of encouraging an involved officer to appear before the UFRB. At a minimum, if officers do continue to sometimes attend UFRB meetings, the Bureau should consider requiring the facilitator to prevent emotional appeals and ensure that officers and Board members limit the discussion to factual issues.

The Bureau's Corrective Actions

Recommendation 15: The Bureau should consider refinements to the Emergency Medical Custody Transport Directive to more clearly define PPB officers' responsibilities.

Recommendation 16: Consistent with its revised Tactical Doctrine, the Bureau should consider revising its foot pursuit policy to include additional factors officers should weigh in deciding whether to initiate or continue a foot pursuit.

Recommendation 17: In the interest of transparency, the Bureau should consider whether a portion of its CIT training could occasionally be opened and training materials made available to interested members of the public.

Recommendation 18: The Bureau should consider whether the circumstances surrounding the Chasse case can be developed into a training video for the benefit of all Bureau members.

Recommendation 19: The foot pursuit data collection and tracking initiative should continue to be supported by the Bureau and the data developed from the initiative should be periodically made available to the public.

Supervisory Issues

Recommendation 20: The Bureau should consider devising a Directive requiring any sergeant or lieutenant involved in a significant use of force incident to relinquish his or her role as supervisor once the force incident is over and to call for another supervisor to respond to the scene and assume command of the response to the incident. Any supervisor who responds to an incident in which another supervisor has been involved also should have a concomitant duty to assume command and relieve the involved sergeant or lieutenant of his or her on-scene responsibilities.

The Decision to Carry Mr. Chasse to the Patrol Vehicle

Recommendation 21: The Bureau should consider revising its policies and training to prohibit officers' transport of subjects in maximum restraints. It should also review its policy and training on carrying subjects in maximum restraints, explore alternative methods for moving subjects, and modify its training doctrines accordingly so that officers are at least instructed to minimize the distance they carry subjects in maximum restraints.

Personnel Issues

Recommendation 22: The Bureau should consider adopting a policy of not hiring lateral candidates from other law enforcement agencies while they are the subjects of pending administrative investigations.

Recommendation 23: The Bureau should consider extending its administrative assignment policy to officers involved in in-custody deaths.

Transit Police Division Challenges

Recommendation 24: The Bureau should consider initiating a dialogue with TriMet and participating agencies to forge an agreement that participating agencies will ensure complete and timely cooperation of their personnel, including an agreement to be promptly interviewed in any subsequent PPB criminal or Internal Affairs Division investigation. Any agreement should include specific language that ongoing civil litigation should not be a reason for refusing to provide PPB timely access to these individuals.

Recommendation 25: The Bureau should consider the potential challenges, coordination, and uniformity issues presented by the multi-jurisdictional nature of the Transit Division and work with its counterparts to ensure all Transit officers have been trained in and will be held accountable to a set of core policies and key tactical training doctrines to better ensure that when officers are presented with dynamic events, there is a pre-existing, coordinated, and consistent understanding of how each participant will respond to that event.

Transparency

Recommendation 26: IPR should consider whether it is appropriate to establish a more visible presence during the pendency of critical incident investigations to assure the public that an independent entity will be helping to shape the investigation and participating in the review to ensure thorough, fair and principled fact gathering and outcomes.

Recommendation 27: Outside review of critical incidents should not be dictated by the pace of any resulting litigation.

Responses to the Report

OFFICE OF MAYOR SAM ADAMS
CITY OF PORTLAND

July 22, 2009

LaVonne Griffin-Valade
City Auditor
1221 SW 4th Avenue, Room 140
Portland, Oregon 97204

Subject: Mayor Adams' response to the Office of Independent Review Groups' report on the Chasse investigation

Dear Auditor Griffin-Valade,

I would like to thank the Portland City Auditor for overseeing the completion of an independent review of James Chasse's tragic death on September 17, 2006. While nothing in this report can erase the emotional pain for Mr. Chasse's family and friends, a comprehensive examination of Portland Police Bureau policies and procedures provides an opportunity to reflect and advance with an improved understanding of the challenges facing citizens suffering from mentally illness. I am pleased with the Bureau's cooperation with the independent review process and the report's recognition that the Bureau opened up "its vault of materials and personnel to exacting outside review."

The report contains several suggested recommendations which merit additional investigation and potential implementation. However, the report also highlights the progress the Bureau has made since this tragedy occurred in 2006. Mr. Chasse's death, several changes have already been implemented within the Bureau including the following:

- Mandatory Crisis Intervention Team training for all officers;
- Training officers to consider the severity of the crime before initiating a foot pursuit;
- Requiring officers to give paramedics complete information before deciding how to transport subjects; and
- Roll call videos on foot pursuits, Taser use, and other subjects.

The report further states that the Bureau's Training Division Analysis and Recommendations contained "eight specific recommendations, all of which the Bureau has implemented." I am encouraged by the report's acknowledgment that "the Bureau's resolve to identify the multitude of systemic issues stemming from Mr. Chasse's death, develop remedial measures, and ensure timely implementation of those recommendations for reform is testament to PPB performing at its highest level."

It is my goal as Mayor and Police Commissioner to ensure that the Bureau continues to make substantial progress in its treatment of all people in the City of Portland. I look forward to working with the Bureau to implement additional changes in the future.

Best Regards,

Sam Adams
Mayor
City of Portland

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(503) 823-4120 ♦ mayorsamadams.com

CITY OF PORTLAND, OREGON

Bureau of Police
Sam Adams, Mayor
Michael Reese, Chief of Police
1111 S.W. 2nd Avenue • Portland, OR 97204 • Phone: 503-823-0000 • Fax: 503-823-0342

Integrity • Compassion • Accountability • Respect • Excellence • Service

July 22, 2010

Ms. LaVonne Griffin-Valade
City Auditor
1221 S.W. 4th Avenue, Room 310
Portland, OR 97204

Subject: Portland Police response to the Office of Independent Review Group's report on the Chasse investigation

Dear Ms. Griffin-Valade,

I appreciate the opportunity to review and respond to the draft report and recommendations from the OIR Group regarding the 2006 Chasse investigations. The tragic death of James Chasse on September 17, 2006 has had a profound impact on the City of Portland, including all of us in the Portland Police Bureau. In the past four years, we have made many changes to our policies, procedures, and the training we provide to our officers and supervisors. We have made changes, not only in the way we investigate use of deadly force and in-custody deaths, but have worked to improve the process in which we review these events. As a progressive organization, we welcome input and recommendations from all sources with the goal of identifying all areas where we can improve and work more closely with the community.

I would like to thank OIR Group for their thorough and professional review of our investigation. They have appropriately taken into account and acknowledged those changes we have made over the past several years and provided us with thoughtful and constructive recommendations. We agree with the vast majority of these recommendations, some of which have already been implemented. For the few where we have concern, we are committed to thoroughly reviewing them with an open mind, conducting further research and finding the practice that will work best in the City of Portland.

Ms LaVonne Griffin-Valade

OIR Review
July 22, 2010

I am pleased, even though their comments and recommendations are based on the review of this one investigation, that the OIR Group has recognized the Portland Police Bureau as being, "head and shoulders above most comparable agencies with regard to the way in which it investigates critical incidents." We, like OIR, believe there will always be room for improvement.

The Portland Police Bureau is an excellent organization, full of talented, hard working professionals who are dedicated to serving the citizens of Portland. We are committed to being transparent and not only willing to self critique in order to make change, but willing to accept outside input in order to grow and improve as a police agency. I look forward to working with you, Director Baptista, and all of your staff in all future reviews and assessments of the work we do for the City of Portland.

Sincerely,

Michael Reese

MICHAEL REESE
Chief of Police

Recommendation #1
The Bureau should consider adopting internal protocols for in-custody death investigations that recognize the advantage of on-scene face-to-face interviews for civilian eyewitnesses and the need to conduct those interviews shortly after the incident has occurred if practicable. If conducting such interviews immediately after the event is not practicable, that fact should be noted in the investigative file. *Agree. This is the current practice in the Homicide detail. We agree that more can be done to ensure that better documentation is done when deviations are made. We are going to incorporate this into the Detective Division SOP.*

Recommendation #2
The Bureau should consider revising internal investigative protocols so that the transport of officers from the scene is documented. *Agree and this is also the current practice with the Homicide detail that should be better documented.*

Recommendation #3
The Bureau should consider initiating discussions with the union to reform protocols so that involved personnel can be interviewed about their actions contemporaneous with the incident. *Agree. This is something that has been ongoing for years and we are again looking at several options for getting quicker interviews. We will be working with the District Attorney, IPR and the Unions to improve our process.*

Recommendation #4
The Bureau and the City should consider initiating dialogue with AMR to develop protocols ensuring future cooperation of the private ambulance company in PPB in-custody death investigations. *We agree with this concept and will be looking at several options to ensure better cooperation.*

Recommendation #5
The Bureau should consider adding representatives of the Training Division and Internal Affairs Division to their in-custody death scene response. *This has been tried in the past in response to the PARC review, our initial experience was not found to be productive for a variety of reasons. We are going to revisit this issue and determine if this can be done in a more useful manner.*

Recommendation #6
The Bureau should consider creating an internal policy that would set a realistic but certain deadline by which the Detectives' notebook must be presented to IAD. Divergences from such an internal policy should be based on good cause and only after obtaining written approval at the Assistant Chief level. *We agree but also realize that each case presents different challenges and we will be attempting to balance the need for complete and thorough investigation with the need for quick resolution. Requiring A/C approval will ensure accountability.*

Recommendation #7
The Bureau should consider drafting internal policies recognizing the critical importance of a robust IAD function and ensuring that resources not be diverted away from this unit. *Agree with the concept. We will research and consider if internal policy is the best place to document this. This particular case caught us in transition from having sworn investigators to non-sworn investigators. We are committed to this and we were able to preserve our non-sworn investigators during the last budget process.*

Recommendation #8
In critical incident investigations where outside government agencies place roadblocks on access to information or witnesses, PPB should consider enlisting the assistance of its Commissioner and/or City Council to help remove those roadblocks. *Agree.*

Recommendation #9
In critical incident investigations where outside entities successfully prevent timely access to important witnesses, the PPB should consider the evidence already obtained from the witness, the potential value in obtaining delayed information from the witness(es) in question, and determine whether the IAD investigation should proceed without the additional information. *Agree.*

Recommendation #10
In shootings and in-custody deaths involving members of outside law enforcement agencies as either participants or witnesses, Detectives should be instructed and trained to question these individuals regarding administrative issues when they interview those outside members, on the assumption that IAD may not be able to timely interview them. *Agree. We will be looking at the combined effort of IAD and Detectives.*

Recommendation #11
The Bureau should consider requesting the Training Division devise protocols to ensure that equipment issues are addressed in their analysis. With particular respect to breathing guards, we recommend that the Bureau consider whether it should ensure that each patrol car is outfitted with such a device. *Agree and this is current practice. Each car is now outfitted with breathing guards, and they are listed on the inspection checklist.*

Recommendation #12
In cases where tactical decision making may have resulted from a lapse of supervision, the Bureau should encourage rather than limit IAD to develop these issues in its investigation. *Agree and this is current practice.*

Recommendation #13
The Bureau should consider modifying Use of Force Review Board protocols so that in cases in which new evidence is developed and considered by the Use of Force Review Board, the Training Division should be contacted to determine whether a supplemental analysis and presentation to the Board is warranted. *Agree.*

Recommendation #14
The Bureau should consider revising its protocols so that all UFRB members are notified of the final outcomes of the cases in which they participate. *Agree.*

Recommendation #15
The Bureau should consider making available during the UFRB additional copies of the investigative materials so that all Board members can readily access a given transcript or diagram during the meeting. *Agree and this is the current practice.*

Recommendation #16
The Bureau should reconsider the advisability of encouraging the involved officer to appear before the UFRB. *The Bureau will look at this and this issue may be addressed by the structure of the new board. The new facilitator will be able to control the content of information provided by the officer limiting the information to clarifying information and not mitigating information.*

Recommendation #17
The Bureau should consider refinements to the Emergency Medical Custody Transport Directive to more clearly define PPB officers' responsibilities. *Agree. This has been done and is the current practice.*

Recommendation #18
Consistent with its revised Tactical Doctrine, the Bureau should consider revising its foot pursuit policy to include additional factors officers should weigh in deciding whether to initiate or continue a foot pursuit. *Agree and this is our current practice.*

Recommendation #19
In the interest of transparency, the Bureau should consider whether a portion of its CIT training could occasionally be opened and training materials made available to interested members of the public. *Agree except where disclosure of those portions that would negatively impact public and officer safety.*

Recommendation #20
The Bureau should consider whether the circumstances surrounding the Chasse case can be developed into a training video for the benefit of all Bureau members. *Agree. We have done some training videos related to specific portions of this event. We are looking at preparing an overall video covering this incident.*

Recommendation #21
The foot pursuit data collection and tracking initiative should continue to be supported by the Bureau and the data developed from the initiative should be periodically made available to the public. *Agree. The information is continuing to be collected and, under the new ordinance, is available through IPR*

Recommendation #22
The Bureau should consider devising a Directive requiring any sergeant or lieutenant involved in a significant use of force incident, where practical, to relinquish his or her role as supervisor once the force incident is over and call for another supervisor to respond to the scene and assume command of the response to the incident. Any supervisor who responds to an incident in which another supervisor has been involved also should have a concomitant duty to assume command and relieve the involved sergeant or lieutenant of his or her on scene responsibilities. *Agree and this is the current practice.*

Recommendation #23
The Bureau should consider revising its policies and training to prohibit officers' transport of subjects in maximum restraints. It should also review its policy and training on carrying subjects in maximum restraints, explore alternative methods for moving subjects, and modifying its training doctrines accordingly so that officers are at least instructed to minimize the distance they carry subjects in maximum restraints. *Agree. The Bureau made a training video in July 07which covered maximum restraint application. The Training Division will be reviewing our practice in this area.*

Recommendation #24
The Bureau should consider adopting a policy of not hiring lateral candidates from other law enforcement agencies while they are the subjects of pending administrative investigations. *Agree when the allegations are of serious misconduct.*

Recommendation #25
The Bureau should consider extending its draft a policy requiring members directly involved in fatal shootings be placed in administrative assignments for at least one month following the Grand Jury, subject to month-to-month review by the members division commander and Assistant Chief to officers involved in in-custody deaths as well. *Agree. This was already incorporated into a later draft of the policy.*

Recommendation #26
The Bureau should consider initiating a dialogue with TriMet and participating agencies to forge an agreement that participating agencies will ensure complete and timely cooperation of their personnel, including an agreement to be promptly interviewed in any subsequent PPB criminal or Internal Affairs Division investigation. Any agreement should include specific language that ongoing civil litigation should not be a reason for refusing to provide PPB timely access to these individuals. *Agree and this is in progress. We are working on a pilot project where agencies conduct a joint investigation.*

Recommendation #27
The Bureau should consider the potential challenges, coordination, and uniformity issues presented by the multi-jurisdictional nature of the Transit Division and work with its counterparts to ensure all Transit officers have been trained in and will be held accountable to a set of core policies and key tactical training doctrines to better ensure that when officers are presented with dynamic events, there is a pre-existing, coordinated, and consistent understanding of how each participant will respond to that event. *Agree in concept and will research options. The Chief and the Commander of the Transit Division will be working with the chiefs of all involved agencies to achieve this.*

OIR Group provides consultant services to law enforcement agencies for officer-involved shootings, use of force incidents, investigative protocols, force policies, procedures, and training, as well as all forms of alleged police misconduct. Additionally, in response to requests from the Los Angeles County Sheriff's Department and other law enforcement agencies, OIR Group attorneys have provided training on investigations and direct feedback to field supervisors and internal affairs investigators.

Since 2001, attorneys with OIR Group have contracted with Los Angeles County to provide independent civilian oversight for all internal affairs and internal criminal investigations functions within the Los Angeles County Sheriff's Department, the largest sheriff's department in the nation. In this capacity, these attorneys have been known as the Office of Independent Review ("OIR"). Specifically, within the last eight years, OIR has reviewed high-profile officer involved shootings, inmate murders in county jails, and scores of less-than-lethal force incidents on patrol, in the jails, and in the courts. A vital part of the OIR's review is to ensure thorough and objective investigations into these critical incidents. For each officer-involved shooting, death in custody, and major force incident, OIR is mandated to assess the quality of the completed investigation and where lacking, provide feedback designed to ensure that the investigation is thorough. When investigations fall short of minimal standards, OIR has issued public reports highlighting those shortcomings and the potential impact on credibility with the public as well as risk management implications.

Michael Gennaco is a founding member and Chief Attorney of the Office of Independent Review. Mr. Gennaco has also been appointed by a federal judge as an expert consultant to assist in designing an independent review agency for the California Department of Corrections and Rehabilitation. Mr. Gennaco has also assisted other law enforcement entities, including the San Diego County Sheriff's Department, Oakland Police Department, Inglewood Police Department, Pasadena Police Department, Torrance Police Department and Palo Alto Police Department regarding review of officer-involved shootings, force, internal affairs and oversight matters.

Mr. Gennaco served for over six years as an Assistant United States Attorney for the Central District of California. As Chief of the Civil Rights Section, he was responsible for overseeing all investigations and allegations of federal civil rights violations. Prior to that, Mr. Gennaco was a federal prosecutor for eight years for the Criminal Section of the United States Department of Justice Civil Rights Division. Mr. Gennaco is a graduate of Dartmouth College and received his JD from Stanford Law School.

Robert Miller is Deputy Chief Attorney of Los Angeles County's Office of Independent Review and a founding member of OIR Group. He graduated from Stanford University and UCLA School of Law. He came to the OIR from a fifteen-year career in the Los Angeles County District Attorney's Office where he prosecuted murders, other violent felonies and white collar cases, in particular environmental crimes. His independent oversight duties for Los Angeles County include review of officer-involved shootings as well as misconduct cases at Sheriff's patrol stations and the central jail. He has authored special reports on topics ranging from alcohol-related misconduct to inmate-on-inmate murder. Mr. Miller has participated in a number of recent OIR Group projects for a wide variety of cities and law enforcement agencies focused on officer-involved shooting investigations, use of force investigations and other critical incidents.

Julie Ruhlin joined OIR after working as a consultant with the Police Assessment Resource Center in Los Angeles, where she worked on police policy and training and issues. Her primary responsibilities at OIR involve monitoring issues surrounding the county jails, including uses of force, allegations of deputy misconduct, and inmate deaths. Ms. Ruhlin also has reviewed numerous officer-involved shootings and other critical incidents in her work with the Los Angeles County Sheriff's Department. She has served as a court-appointed expert to assist in design of an internal civilian oversight entity for misconduct investigations in the California prison system. She came to her career in police oversight from a private law practice in criminal defense and civil rights litigation. She also served as a law clerk to the Hon. Christina A. Snyder of the United States District Court. She graduated from American University and the University of Southern California School of Law.

1099

Agenda No.

REPORT NO.

Title

Accept the Report to the City of Portland Concerning the In-custody Death of James Chasse (Report)

INTRODUCED BY Commissioner/Auditor: **Auditor LaVonne Griffin-Valade**	CLERK USE: DATE FILED JUL 23 2010
COMMISSIONER APPROVAL Mayor—Finance and Administration - Adams Position 1/Utilities - Fritz Position 2/Works - Fish Position 3/Affairs - Saltzman Position 4/Safety - Leonard	LaVonne Griffin-Valade Auditor of the City of Portland By: _____ Deputy
BUREAU APPROVAL Bureau: Auditor Bureau Head: LaVonne Griffin-Valade Prepared by: Carol Kershner Date Prepared:July 22, 2010	**ACTION TAKEN:** JUL 28 2010 ACCEPTED
Financial Impact Statement Completed ☐ Amends Budget ☐ Not Required ☒	
Council Meeting Date **July 28, 2010**	
City Attorney Approval	

AGENDA
TIME CERTAIN ☒ **Start time: 6:00 pm** **Total amount of time needed: 1 hour** **(for presentation, testimony and discussion)**
CONSENT ☐
REGULAR ☐ **Total amount of time needed: _____** **(for presentation, testimony and discussion)**

FOUR-FIFTHS AGENDA	COMMISSIONERS VOTED AS FOLLOWS:	YEAS	NAYS
1. Fritz	1. Fritz	✓	
2. Fish	2. Fish	✓	
3. Saltzman	3. Saltzman	—	
4. Leonard	4. Leonard	—	
Adams	Adams	✓	