The Portland Police Bureau: Officer-Involved Shootings and In-Custody Deaths

Third Follow-Up Report

Police Assessment Resource Center
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About PARC

The **Police Assessment Resource Center (PARC),** a non-profit organization, is dedicated to strengthening effective, respectful, and publicly accountable policing. PARC serves as an "honest broker," working in cooperation with law enforcement executives, civic and government officials, civilian oversight professionals, and other interested constituencies to improve police performance. Based in Los Angeles, PARC provides direct services to jurisdictions throughout the United States and serves as a national resource center specializing in the formulation and dissemination of model policies and procedures to manage and reduce the risk of police misconduct.

Through its direct services, PARC assists officials in individual jurisdictions as they develop and strengthen oversight systems. PARC conducts reviews of police policies and practices; evaluates external and internal oversight mechanisms; collects and analyzes relevant data; performs accountability audits; and helps police leaders develop and implement management strategies that promote accountability.

As a national resource center, PARC performs research on issues of concern among law enforcement professionals and community members, and provides guidance regarding policing practices and oversight of the police. PARC publishes a quarterly newsletter, *Police Practices Review*; maintains an informational website; sponsors forums on issues and trends in the field of policing; conducts and publishes independent research on emerging issues and enduring challenges in policing; and catalogues model policies and procedures.

A copy of this report is available on-line at http://www.parc.info/portland_police_bureau-publications.chtml.

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M E M O R A N D U M

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

From: Gary Blackmer, City Auditor
Date: February 17, 2009

Subject: 2009 Review of Officer-involved Shootings

This is the fourth report presented by my office, as called for in the City Code. City Council requested that these reviews emphasize policy-level recommendations with the goal of identifying any strategies for reducing the possibility of future incidents. My office developed a review process and hired the Police Assessment Resource Center (PARC) to conduct the periodic evaluations, beginning in 2003. I also would like to point out that, with these regular reviews, Portland set a standard of accountability that very few other cities have been willing to match.

To date, four reports have reviewed a total of 70 closed shooting incidents or deaths in police custody and produced 124 recommendations. I am very pleased to see many substantial changes undertaken by the Portland Police Bureau (Bureau), and especially by line officers, in response to those recommendations.

2008 was the second year in a row when the Bureau had only 2 incidents of officer-involved shootings. This is a remarkable reduction from 9 or 10 incidents per year the Bureau experienced in the period leading up to the 2003 report. Other factors may have contributed to the change but, fundamentally, officers deserve immense credit for changing their decision-making about using deadly force.

I want to call the reader's attention to another pattern that is woven into this report. The entire organization is starting to show the ability to identify areas of improvement and respond with constructive changes. Every good organization learns and improves, and the transformation I see in the Bureau exceeds my best expectations, and can produce many other good results for our community.

You will also find responses from Chief of Police Rosie Sizer and Police Commissioner Dan Saltzman attached at the back of the report. Their leadership is a key element of past and future success and I have great confidence in them.

I urge the City Council and our community to recognize and support the Bureau's progress. Only with a continuous, constructive dialogue among all the interests can there be lasting change in the way the Portland Police Bureau meets the needs of our community.

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Executive Summary and Introduction

This Report describes an increasingly excellent police department. Chief Rosanne Sizer and her command staff have worked diligently and in good faith to improve the Portland Police Bureau ("PPB" or "Bureau"). To the extent this has meant implementation of the Police Assessment Resource Center ("PARC") recommendations, the Chief has done so effectively and with seriousness of purpose. Importantly, the current administration has built upon PARC's recommendations and developed first-rate new policies. The PPB is indeed in a progressive mode, with an increased capacity for self-critical identification of issues and formulation of solutions. We conclude that the PPB has made substantial progress since we first looked at it in 2002 and 2003.

PARC first examined the PPB in 2002 and issued its initial report in 2003. In an effort to ensure that the PPB's policies and practices relating to officer-involved shootings and in-custody deaths were up-to-date and consistent with good practice, the Independent Police Review Division of the Office of the Portland City Auditor ("IPR") retained PARC in 2002 to examine those policies and practices. PARC's original report made 89 recommendations for changes in the PPB's deadly force policies, investigation and review procedures and practices, tactics, and information management. Our First Follow-Up Report in 2005 looked at the PPB's and the City's responses to 28 of the original 89 recommendations. PARC made ten new recommendations.

The Second Follow-Up Report in 2006 found that the Police Bureau, under the leadership of both current Chief Rosanne Sizer and former Chief Derrick Foxworth, had responded very positively to most of the 25 recommendations examined that year. Those recommendations involved the PPB's internal processes for reviewing officer-involved shootings and in-custody deaths and the Bureau's management of records and information. In addition to the 25 older recommendations, PARC made 16 new ones. Chief Sizer indicated a laudable willingness consider them as well as the relatively few PARC recommendations relating to the review process that had not thus far been adopted by the PPB.

In this third follow-up to its 2003 report, PARC examines how the PPB has responded to the remaining 36 recommendations in the 2003 Report not previously considered in detail in a follow-up report and reviews 12 officer-involved shootings. One of the shootings occurred in 2002, before the publication of the PARC Report. One of the cases occurred in late 2003; four took place in 2004; and six happened in 2005. We also examine recent developments in the PPB since our last follow-up report in 2006. Of particular significance are a newly crafted use of force policy and the professionalizing of the role of Incident Commander in critical incidents, both of which will be discussed in this report.

It is gratifying to see that implementation of the PARC recommendations is credited with a substantial reduction in officer-involved shootings, as the City Auditor has found. PARC's goal has been to identify and reduce to the greatest extent possible deaths and serious injury to officers and suspects alike. We recognize that no matter how good a police department's policies, training, and supervision are, officer-involved shootings can never be eliminated in their entirety. The unpredictability of circumstances requires that officers measure risks and exercise their judgment, often in split-second decisions, regarding deadly force. The best outcome is one in which only necessary and unavoidable shootings occur. In general, those are shootings that could not have been avoided by different or better officer tactics. Our reports offer recommended policies, procedures, and training to minimize the risk of shootings without compromising officer safety. Our reports also are aimed to help the PPB analyze and distinguish necessary from unnecessary shootings and take appropriate steps to self-correct when necessary. This report, like previous reports, focuses on inculcating a methodology for identification and correction of problems by the PPB itself.

PARC's role is gradually shifting. In the early years, PARC sought to expose the PPB to promising national practices to manage the risk of unnecessary force, encouraged the PPB to adopt them, and then to follow up to determine whether such recommendations had been adopted. As the City Auditor has noted, the number of officer-involved shootings has declined significantly.

More recently, PARC is examining how well the PPB identifies shootings that could or should have been avoided and initiates corrective action. Working with the IPR, the PPB is improving the quality of investigation and analysis of critical incidents. The system for the receipt and resolution of complaints by the public has greatly improved, as has internal investigations and analyses of these complaints and other serious incidents. The relationship between the PPB and IPR is mutually respectful and productive. So also are improved relationships in the PPB/IPR/ Citizen Review Committee ("CRC") triangle.

The stage has been set, and PARC's role now is to evaluate whether and how well the PPB is identifying and correcting problems. Thus, the number of new recommendations we offer is declining, while our critique of the mechanisms for self-correction expands. The next step is to introduce a methodology developed by PARC under the guidance of the City Auditor for the PPB to have at its disposal the tools that PARC itself has used to analyze critical incidents and test the quality of the police organization's response. Ultimately, the role of an outside organization like PARC will be to appraise how well the PPB transparently, correctly, and meaningfully identifies and solves issues arising from use of force.

Most of the officer-involved shootings that we review in this report occurred in 2004 and 2005. As we have in the past, we examine the shootings against the backdrop of policies and training as they existed at the time of the shooting. PARC's role in general does not involve criticizing the specific actions of individual officers or questioning the discipline that officers may or may not have received in particular cases. Because all PARC recommendations relating to policy, procedure, and training are aimed toward ensuring a high level of officer safety and performance, however, this report continues to note aggregate trends or dominant issues in officer performance among the reviewed cases and provides examples of such principal concerns.

Where policy or training changes since the original recommendations have appeared to work or positively affect the outcomes in various cases, we note such progress. If

subsequent revisions of policy or training that makes it less likely today that such a shooting would occur, we attempt to note it. Likewise, we note if, despite prior recommendations, problems persist or specific previously highlighted areas continue to be cause for concern. To the extent that we have discovered new trends in the reviewed cases, we address them. When we make recommendations beyond those advanced in the 2003 PARC Report or subsequent follow-up reports, they are set forth in bold in the text and are numbered sequentially starting at "2008.1" to differentiate them from the 89 original recommendations.

Chapter 1 of this Report considers field supervision during critical incidents. We have identified a trend of deficient supervision in the past, and the PPB has taken steps to expand training for sergeants in the management of critical incidents. It recently created the group of specialized Incident Commanders described earlier. These steps hopefully will help decrease in the future the supervision deficiencies that the reviewed cases illuminated.

The 2003 PARC Report recommended that the Bureau examine more closely whether the field tactics that officers employ are consistent with the training that such officers receive and with best practice nationally. By considering officer actions and identifying aggregate trends, it highlighted high-risk vehicle stops, vehicle pursuits, foot pursuits, the use of cover, crossfire, and bystander endangerment as areas that the Bureau needed to address. It also considered issues relating to accidental discharge and less lethal force options. Chapter 2 considers the Bureau's progress toward implementing the 2003 and subsequent recommendations about these field tactics by considering both the Bureau's changes in policy and training relating to such areas and, when appropriate, whether, in the context of officer-involved shootings, the field tactics that officers employ are consistent with such policy and training.

Chapter 3 reviews the status of recommendations made in PARC's 2003 Report relating to the quality of the PPB's investigation of officer-involved shootings. Eleven of the twelve cases reviewed for this report capture the PPB in the midst of implementing many of the PARC recommendations regarding internal investigation and review. As the chapter

describes, the PPB has achieved a clear and notable increase in quality and thoroughness of its homicide investigations. The quality and care taken in documentation have increased. Interviews with officers and witnesses are generally more objective and comprehensive. The preservation of the crime scene and procedures for the collection of evidence have improved. The Internal Affairs investigations also showed improvement.

After looking closely at the PPB during 2008, we are left with the impression that the PPB is making a commendable effort to assume greater internal accountability and perform self-critical analysis. Should these trends continue, strengthen, and become woven into the institutional fabric, the PPB should become a more self-correcting enterprise. Two recent advances, among several, by the Bureau exemplify the effort from within to formulate progressive policies: the new use of force policy and the creation of the job of Incident Commander.

I. USE OF FORCE POLICY

In March 2008, the PPB adopted a revised use of force policy that broke new ground nationally in its explicit recognition that police officers must strive to use lesser levels of force even if higher levels of force might otherwise be permissible in the circumstances:

> **§1010.20. Physical Force.** The Portland Police Bureau recognizes that duty may require members to use force. The Bureau requires that members be capable of using effective force when appropriate. It is the policy of the Bureau to accomplish its mission as effectively as possible with as little reliance on force as practical.
>
> The Bureau places a high value on resolving confrontations, when practical, with less force than the maximum that may be allowed by law. The Bureau also places a high value on the use of de-escalation tools that minimize the need to use force.
>
> The Bureau is dedicated to providing the training, resources and management that help members safely and effectively resolve confrontations through the application of de-escalation tools and lower levels of force. **It is the policy of the Bureau that members use only the** force reasonably **necessary under the totality of circumstances** to perform **their duties and resolve confrontations effectively and safely**. The Bureau expects members to develop and display, over **the course** of their practice of law enforcement, the skills and abilities **that allow** them to regularly resolve confrontations without resorting to **the higher** levels of allowable force.

Such force may be used to accomplish the following official purposes:

a. Prevent or terminate the commission or attempted commission of an offense.
b. Lawfully take a person into custody, make an arrest, or prevent an escape.
c. Prevent a suicide or serious self-inflicted injury.
d. Defend the member or other person from the use of physical force.
e. Accomplish some official purpose or duty that is authorized by law or judicial decree.

When determining if a member has used only the force reasonably necessary to perform their duties and resolve confrontations effectively and safely, the Bureau will consider the totality of circumstances faced by the member, including the following:
a. The severity of the crime.
b. The impact of the person's behavior on the public.
c. The extent to which the person posed an immediate threat to the safety of officers, self or others.
d. The extent to which the person actively resisted efforts at control.
e. Whether the person attempted to avoid control by flight.
f. The time, tactics and resources available.
g. Any circumstance that affects the balance of interests between the government and the person.

The Bureau's levels of control model describes a range of effective tactical options and identifies an upper limit on the force that may potentially be used given a particular level of threat. However, authority to use force under this policy is determined by the totality of circumstances at a scene rather than any mechanical model. (Emphasis in original).

Portland's policy advances effective policing, promotes officer safety, and promises positive community relations. The use of force policy should be effective because it should result in better and safer arrests and increased crime prevention and control. In turn, there should be less litigation about excessive force, and the dollars saved can be invested in crime prevention. The new policy promotes officer safety by leading to fewer confrontations that put police officers in danger of serious injury. The policy promises to promote community relations by reducing the tension and anger that excessive force can generate. We praise Chief Sizer and the other dedicated individuals who helped to formulate this farsighted policy.

II. INCIDENT COMMANDERS

Likewise, the leadership of the PPB came to a critically important insight into why the management of critical incidents on occasion goes awry. Responsibility for overall leadership in such incidents can become confused and dispersed without anyone clearly in charge. In response, the PPB has created a cadre of seasoned leaders to act as Incident Commanders in critical incidents where the SERT (Portland's SWAT team) and Hostage Negotiating Team ("HNT") are called out. The Incident Commander will take charge and coordinate the efforts of first responders, SERT, and HNT. Implementation of this sensible solution to confusion over who is really in charge has eluded other leading police departments. Turf battles between the local precinct commanders, the SWAT team, the negotiators, and department brass have doomed efforts elsewhere to create a similar role for professional Incident Commanders. To have overcome these obstacles, as Chief Sizer and her leadership group have done, is praiseworthy.

III. THE CURRENT REPORT

PARC reviewed twelve officer-involved shootings for this report. We uniformly reference these cases by number, as presented in Table 1, below.

TABLE 1: SUMMARY OF OFFICER-INVOLVED SHOOTING CASES REVIEWED

CASE NUMBER	DATE OF INCIDENT	SUMMARY	AREAS OF DISCUSSION IN REPORT
Case 1	February 2002	Officers observe a man assaulting a young child. They fatally wound the man as he holds the child in his arm.	Homicide Investigation—Witnesses & Interviews
Case 2	December 2003	Officers confront a suspect in a stolen vehicle after a failed surveillance job. Officers fatally wound the suspect after he begins to maneuver the vehicle toward them.	Deficient Supervision; Homicide Investigation—Witnesses & Interviews
Case 3	January 2004	A man holding his girlfriend hostage is fatally shot by officers.	AR-15

Case 4	November 2004	Officers responding to an armed robbery call give pursuit to a suspect, confronting him on a sidewalk and fatally wounding him.	Foot Pursuits; Bystander Endangerment; 21-Foot Rule; Homicide Investigation—Documentation; Homicide Investigation—Witnesses & Interviews; IA Investigation; Training Bureau Analysis
Case 5	December 2004	Officers pursue a suspect in a car reported stolen. The suspect flees on foot and fires multiple times at officers giving chase, who return fire. The suspect lays prone between a lawn and a fence and dies as, first, patrol officers and, then, SERT officers attempt to secure him.	Deficient Supervision; Provision of Medical Care; High-Risk Vehicle Stops; Use of Cover; Taser; Beanbag Shotguns; Homicide Investigation—Documentation; Homicide Investigation—Witnesses & Interviews; IA Investigation; Training Bureau Analysis; After-Action Reports
Case 6	February 2005	Officers initiate a traffic stop, but the vehicle speeds away as officers approach. The truck stops after a short distance. Officers approach with guns drawn. One opens the door of the truck, firing a single round that the officer says was an accidental discharge. The round exits the cab of the vehicle, ending up in the closet of a nearby civilian. No one is injured.	High-Risk Vehicle Stops; Accidental Discharges; Homicide Investigation—Witnesses & Interviews; IA Investigation
Case 7	February 2005	An officer serving a search warrant accidentally fires his gun as he attempts to look under the bed on the second floor of the residence. The bullet lodges between the two floors of the house, with no one injured.	Accidental Discharges; IA Investigation; Training Bureau Analysis
Case 8	March 2005	Officers respond to a 911 call and encounter the victim of an assault. They enter a residence and encounter the suspect who charges at the officers with a knife. Multiple officers fire. The suspect's wounds are fatal.	Crossfire; AR-15; Homicide Investigations—General; IA Investigation; Training Bureau Analysis
Case 9	March 2005	A man holds multiple hostages at a house. Patrol officers initiate negotiations. SERT is activated. A SERT sniper fires a round when the suspect raises an object and spins around toward officers, fatally wounding the suspect.	Deficient Supervision; Homicide Investigation—Witnesses & Interviews; After-Action Reports
Case 10	February 2005	Officers are dispatched to an apartment complex and encounter a suspect with a knife in the lobby. The suspect advances toward an officer, who fires multiple rounds; another officer fires a less lethal shotgun. The suspect survives.	Bystander Endangerment; Homicide Investigations—General; IA Investigation; Training Bureau Analysis
Case 11	March 2005	Officers briefly pursue a stolen vehicle. The vehicle stops, but the suspect begins to ram a patrol car. The vehicle drives directly at a police vehicle. Officers fire multiple shots at	Shooting at Moving Vehicles; IA Investigation; After-Action Reports

		the driver. The suspect's wounds are nonfatal.	
Case 12	May 2005	Officers respond to a call regarding a man with a knife. The suspect approaches one of the officers, and multiple officers fire, fatally wounding the suspect.	Use of Cover; 21-Foot Rule; Homicide Investigation—Witnesses & Interviews; IA Investigation

In the review of these cases, we considered the following materials:

- The official PPB files of the investigations of each of these incidents, including interviews with officers and civilians, audio tapes, transcripts of 911 calls and MDT transmissions, videotapes, photographs, medical records, and autopsies;

- After-Action Reports and executive review determinations; and

- Additions, changes, and deletions to the PPB policy manual, training materials, and course curricula, and new protocols and practices.

In addition to reviewing the case files, we met with numerous PPB officials and others. At the PPB, we met or spoke with Chief Sizer, representatives of the Detective, Internal Affairs, Training, Tactical Operations, and Records Divisions, the Lieutenant in charge of SERT, and other supervisors and line staff, sworn and civilian. We met with and have spoken frequently with Leslie Stevens, the Director of the Office of Accountability and Professional Standards. Her involvement and assistance greatly facilitated our review. We met with City Auditor Gary Blackmer, and IPR Director Mary-Beth Baptista. We met with a member of the Citizen Review Committee and representatives of community groups, activist organizations, and attorneys concerned with issues related to policing.

PARC retained two consultants—Chief Bernard Melekian and former Assistant Sheriff Michael Graham—with a wealth of sworn law enforcement experience and broad knowledge of policing practices across the country to participate in the case file reviews and in the formulation of the conclusions reached by this report. Chief Bernard Melekian is the Police Chief of Pasadena, California, and has occupied that position since 1996. In

1973, he joined the Santa Monica Police Department where he was promoted through the ranks to Captain. He was among the first canine handlers in Southern California and has been involved in tactical teams at all levels throughout his career. Chief Melekian is the former national secretary for the Police Executive Research Forum, is the President- Elect of the California Police Chiefs' Association, and is a two-term past president of the Los Angeles County Police Chiefs' Association. He chaired the state Attorney General's Blue Ribbon Commission on SWAT policy and was a law enforcement representative to the Council of State Governments' Criminal Justice/Mental Health Consensus Project. Chief Melekian earned a master's degree in Public Administration at California State University, Northridge, and is a doctoral student at the USC School of Policy, Planning, and Development.

Michael Graham was employed by the Los Angeles Sheriff's Department for 32 years, rising through the ranks from Deputy to Assistant Sheriff. Now retired from the Sheriff's Department, he has remained active with the California police Summer Games, the World Police and Fire Games, and the International Association of Chiefs of Police (IACP) Policy Center. He serves as a consultant to the Civil Rights Division of the United States Department of Justice in connection with their pattern and practice investigations of police misconduct in a number of different jurisdictions.

Significant time was devoted to reviewing the twelve investigative files and related material concerning the officer-involved shootings. All the first reviews were done by PARC consultants with significant police oversight experience. Two team members, always including one of the highly experienced law enforcement professionals profiled above, were assigned to each file, with each reviewer providing an independent assessment of the issues in the case. The review team met for a full day on August 11, 2008, to discuss themes drawn from the individual cases and the PPB internal review policies and procedures drafted in response to our recommendations.

Drafts of our final report were provided to the Police Commissioner, the PPB, the City Auditor, IPR, and the City Attorney. Drafts were also provided to, and comments sought

from, members of the review team. After circulating drafts of our report, we met with PPB representatives, the City Auditor, and the director of IPR, to discuss our findings and recommendations, and to respond to concerns about our report.

We carefully considered the constructive suggestions made to us concerning our report by those who read the draft. Neither the PPB nor anyone else who read the draft in any way impinged on our independent judgment as to our findings and recommendations.
The Police Commissioner and PPB were provided an opportunity to respond in writing to our report.

1

Field Supervision

In this chapter, we look at PARC's prior recommendations to improve the performance of supervisors in incidents resulting in a shooting. Ten of the officer-involved shootings happened in 2004 and 2005. One took place in 2003 and another in 2002.

We emphasize that our contract with the city of Portland stipulates that we may not review a shooting until all criminal and possible civil proceedings have concluded or the statute of limitations has run. Accordingly, the PPB may or may not have taken steps in the intervening years to cure the issues we find troubling in these shootings. While we cannot independently know how such reforms may be affecting the behavior of supervisors in the field currently, we have no reason not to take the PPB at its word when it points to reforms which it contends lessen the risk that troubling incidents in the past will recur. The PPB has initiated welcome new reforms in many areas. Where the Bureau has initiated such changes in policy or training in the time since an incident occurred, or any shortcomings in performance were noted, we say so.

We do not doubt that most PPB supervisors perform admirably on a daily basis. Our review of officer-involved shootings revealed, however, some instances where the quality and level of field supervision should have been better. The PPB has proactively created a seasoned cadre of Critical Incident Commanders which should hopefully provide consistent, high level supervision of critical incidents which call for a response by the PPB's SERT team. The expansion of critical incident management training in supervisory school will also help. We describe these significant reforms in greater detail below. We make new recommendations to strengthen supervision at critical incidents not involving the SERT team.

We also appraise in this chapter how well the PPB detected and took reasonable action when confronted with deficient performance by supervisors in the shootings we reviewed for this report. In some instances, the PPB considered the performance of supervisors and took action when they found performance to be lacking. In others, however, the PPB either did not consider the performance of supervisors or considered only the supervisors' policing tactics rather than their ability to supervise or coordinate other officers during the incident.

I. THE IMPORTANCE OF COMPETENT SUPERVISION

As we noted in PARC's 2005 First-Follow Up Report, consideration of critical incidents, including officer-involved shootings, must necessarily "examine the actions and omissions of all those personnel who became involved, or whose involvement should have occurred but did not, through to the incident's conclusion" (2005, p. 49). The presence and level of constructive involvement of supervisors can dramatically shape the outcomes of critical incidents.[1]

PARC issued several recommendations explicitly related to field supervision in its initial Report and considered the topic in both follow-up reports. The 2003 PARC Report, noting that "effective field supervision is essential for the sound management of critical incidents," found "supervision failures [to be] a particularly critical weakness" that "fall well below best practice" in ten of the 30 officer-involved shootings that it reviewed (2003, p. 175, 178). That report issued five recommendations (**Recommendations 7.3** through **7.7**) that addressed recurring, key problems with field supervision, including sergeants failing to effectively assume a proper supervisory role, coordinate officer deployment,

[1] The San Diego Police Department established that "the chances of an officer-involved shooting are reduced 80 to 90 percent...if a supervisor gets to the scene" (Police Executive Research Forum, *Chief Concerns: Exploring the Challenges of Police Use of Force* (April 2005), p. 10). At the conclusion of a use of force policy inquiry, the Fresno Police Department similarly concluded that "the key to preventing excessive use of force is to…ensure that field supervisors are available and have access to officers in the field" as serious incidents unfold (Fresno Police Department, Reportable Use of Force Project, 2003, cited in PERF, *Chief Concerns* (April 2005), p. 41).

issue appropriate tactical instructions, or overrule inappropriate strategies employed by officers under their command. PARC's 2005 First Follow-Up Report re-examined field supervision in critical incidents and described "supervision problems" as a "particularly critical weakness in the cases…reviewed" for that report (2005, p. 51). PARC's 2006 Second Follow-Up again emphasized the importance of on-scene supervisors in critical incidents and recommended that the PPB "foster a culture…that encourages sergeants dealing with situations to seek advice" (**Recommendation 2006.14)**.

II. DEFICIENT SUPERVISION

Recommendation 7.3: *Supervisors should become involved in critical incidents at the earliest possible stage. Dispatchers should inform a sergeant as soon as any potential critical incident reports are received, and officers should be directed to inform a supervisor without delay whenever they encounter such an incident. Supervisors should also be directed to identify every potentially high-risk building search or warrant service as a critical incident requiring an effectively managed response.*

Recommendation 7.4: *Whenever feasible, supervisors should determine the tactical and strategic approaches to be taken to critical incidents, and should direct the actions of involved officers.*

Recommendation 7.5: *The PPB should hold supervisors accountable for the performance of officers under their command during critical incidents.*

Recommendation 7.1: *The PPB should ensure that operational personnel devise a sound plan before action is taken in response to critical incidents whenever it is feasible to do so.*

These 2003 recommendations relating to field supervision originated from the identification of numerous instances across a number of officer-involved shootings in which supervisors should have performed better (2003, p. 177-178). Supervision involves

more than showing up to the scene of an unfolding critical incident. Supervisors, by virtue of their field experience and training, should assess complex, tense, and dangerous situations requiring quick action; make sound decisions; formulate plans; and coordinate the responses of all officers under their command. Supervisors should generally also resist an impulse to take action personally rather than oversee and direct the actions of others.

Three of the twelve shootings reviewed for this report could have been seen as raising questions about the adequacy of supervision. A fourth such case occurred in 2002, prior to PARC's 2003 Initial Report, and, therefore, is not discussed here. Our focus in reviewing these cases was to consider if the earlier recommendations on supervisory performance, and steps taken by the PPB to address deficiencies in such performance, made a difference when officers employed deadly force in these cases. We also consider how well the PPB identified and took appropriate action when faced with cases that raised supervision issues.

- *Case 5.* The situation required coordination between officers, sergeants and multiple units at the scene. The review process, beginning with the staff review, and continuing through the Unit Commander and Use of Force Review Board, properly identified supervision issues, assigned responsibility for deficiencies and took corrective action.

  An even better result would have occurred if the PPB had also looked critically at the performance of other supervisors who were present at various junctures, Sergeants B, C, and D. Sergeant B, one of the first supervisors to arrive at the scene and who made decisions regarding how officers would approach the wounded suspect, was not interviewed by Internal Affairs or Homicide and was not asked to provide a written statement. Sergeant B's performance was not evaluated during the administrative review. Sergeant C, who was likewise involved in the post-shooting decision-making, provided a cursory written report, was similarly not interviewed, and was not considered at any level of administrative review. Sergeant D, who relieved Sergeant C from his post

during the incident, also provided a cursory written report, was not interviewed, and was not considered during review.

- *Case 9.* The PPB proactively explored supervisory issues in an incident when a sergeant did not call out SERT for one hour and forty-five minutes, despite there being reason to believe a suspect was barricaded with hostages. In the After-Action Report, the precinct commander examined the supervisory decision making at the scene and recommended appropriate management. The Use of Force Review Board adopted the commander's analysis and recommendations, and expanded on them.[2]

- *Case 2.* In this incident involving a suspect in a stolen vehicle, coordination of officers and tactical decisions indicated possible supervision issues. The PPB examined some aspects of this case and took corrective action, but leadership and supervision of the unfolding incident were not addressed at any level of administrative review.

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[2] The PPB's SWAT or tactical unit is called the Special Emergency Reaction Team, or SERT. It is charged with tactical support for the Bureau (PPB Policy §720.00). SERT consists of 24 operators and 2 sergeants and is not a full-time team. It is divided into two teams: a perimeter team responsible for sniper or observation duties and an assault team responsible for entries. Each has a team leader or sergeant in charge and an alternate team leader. In addition to SERT, the PPB has a Hostage Negotiation Team (HNT). Although under separate commands, SERT and HNT are usually activated simultaneously and work in concert.

Four situations call for mandatory SERT call-up:

a. A barricaded person: A person using an obstruction (e.g., building, car, etc.) and the threat of deadly force to accomplish a certain goal or, in the case of a criminal, to prevent capture.
b. A hostage situation: An incident involving a person being held by a suspect who is reasonably believed to be armed, as a means of forcing compliance with some demand.
c. A sniper situation: A person, usually concealed, shooting or threatening to shoot at other people.
d. A high-risk search/arrest warrant where there is a potential threat sufficient to require SERT to execute the warrant.

If SERT arrives prior to the Incident Commander arriving at the scene, the on-scene supervisor remains in charge and has the specific responsibility to inform SERT of what transpired before SERT's arrival. At no time does SERT assume ultimate command or control of the incident.

PARC's 2003 recommendations relating to field supervision stressed the importance of holding supervisors accountable for the quality of their supervision. PARC urged that "a review process that systematically fosters emulation and successes and remedy of failures…be considered as an essential basis for the sound management of future critical incidents" (2003, p. 178). In properly examining supervision issues in Cases 5 and 9 and taking corrective management action, the PPB demonstrated its capacity to implement two of our prior recommendations on accountability, **Recommendations 7.3 and 7.4**. The PPB did not, however, fully evaluate supervision in Case 5, and did not explore supervision at all in Case 2.

Recommendation 7.7: *Future supervisory training should emphasize the relevance of critical incident training to these types of incidents, and the Bureau should ensure that supervisors consistently manage operations according to the sound principles such training promotes*.

The Bureau's current training for sergeants at the eleven-day Sergeant's Command School includes a three-day training course on Critical Incident Management that includes both scenario-based and classroom exercises. The PPB reports that the course "is intended to solidify each supervisor's knowledge and understanding of their responsibilities at critical incidents" and "contains ample opportunity for supervisors to apply the concepts in scenarios and table top exercise."

We commend the Bureau for emphasizing this training and are confident that a consistent emphasis on providing sergeants with the skills, experience, and mindset to manage critical incidents proactively and effectively will increase the quality and vigor of supervision as such incidents unfold in the field. Specifically, we applaud expanded training in critical incident management and credit the Bureau for making it a standard part of training for all supervisors. To this extent, the Bureau has worked diligently on the first part of **Recommendation 7.7**.

The PPB must still, as multiple cases propose, continue to work toward evaluating whether supervisors act proactively and affirmatively during serious, critical incidents in all

instances. When patrol officers make poor tactical decisions, administrative reviewers must inquire about and consider specifically the action, or lack of action, of a supervisor. If a supervisor should have been present but was not, the review should consider why that was the case and how the supervisor could arrive more quickly in similar instances in the future. If a supervisor was present but was removed, passive, or distracted, that supervisor must be held accountable for the failure to assert, maintain, and impose his or her authority. If a supervisor is present and active but makes strategic errors, he or she should receive requisite retraining, counseling, or discipline, as appropriate.

Cases 5 and 9 were examples of cases in which supervisors did not fully assume command and control under a single, unified command to manage an incident from inception to conclusion, including the arrival of SERT. As encapsulated in **Recommendation 2008.1,** below, the PPB should draft a policy that specifically states who shall serve as the on-scene supervisor, what that supervisor's duties are, and under what circumstances that supervisor should notify and, if necessary, relinquish command to a superior officer for all critical incidents.

An excellent template for such a policy is PPB Policy §720.00, "SERT and HNT Use," which sets forth the responsibilities of supervisors during the subset of critical incidents that demand activation or deployment of SERT. Section 720 imposes responsibilities upon an "on-scene incident supervisor," who is "the highest ranking supervisor/command officer [assuming] command at the scene of an incident" (PPB Policy §720.00). That supervisor is in charge unless or until another supervisor of equal or higher rank assumes such command. The on-scene incident supervisor "has the authority and responsibility for all police actions during an incident" (PPB Policy §720.00).

Both the Los Angeles Police Department (LAPD) and the Los Angeles County Sheriff's Department (LASD) also have excellent policies in this regard that go further (see LAPD Manual §214 .50; LASD §§110.30 and 110.35). Of particular note is the LASD's policy requiring the on-scene incident supervisor to notify the watch commander of the existence

of the critical incident and, in turn, requiring that the watch commander go immediately to the scene upon notification:

> 5-6/110.35 Incident Commander
>
> The Incident Commander shall make the following notifications in the most expedient manner possible:
> - Watch Commander, who shall respond to the scene without delay
> - Unit Commander, who shall respond if necessary
> - Area Commander or Duty Commander who shall respond if necessary

As set forth below, we recommend much the same for the PPB.

It is our understanding from the PPB that the command and control of many critical incidents currently proceed in the manner consistent with **Recommendation 2008.1** and PPB Policy §720.00. If so, this is encouraging. It nonetheless remains strongly advisable for the PPB to craft a policy relating to the management of serious, critical incidents such that all officers of all ranks know what to expect at the scene of such an incident and know who is ultimately charge at the scene at all times, whether SERT activation is contemplated or not and such that more senior supervisors become aware of unfolding, serious incidents as early as possible and can roll out to the scene as quickly as possible.

Recommendation 2008.1

The PPB should implement policy setting forth the selection, duties, and responsibilities of on-scene supervisors in all critical incidents, even when they do not rise to the level requiring a SERT rollout. The on-scene supervisor should notify unit or area commanders in the most expedient manner possible such that lieutenants and captains can respond to the scene without delay.

Recommendation 7.6: *The PPB should identify all high-risk building searches, high-risk warrant services, and calls regarding armed civilians as "critical incidents."*

A related concern is that the PPB does not currently have a definition of "critical incident" apart from a series of events denominated as such for purposes of notification contained in

PPB Policy §631.34. The Bureau should separately define "critical incident" such that the on-scene supervisor policy suitably applies to all serious unfolding incidents.

Recommendation 2008.2

There should be a single definition of "critical incident" for all purposes. It should include all circumstances described in §631.34. The definition should be expanded to include situations in which a member of the Bureau is injured, killed, uses deadly force, uses physical force resulting in serious physical injury, or is involved in possible criminal activity; or commits a homicide. It also should include situations involving barricaded persons and hostages; "situations that may induce widespread community fear"; "events that are likely to interrupt daily activity on a large scale" or "generate extraordinary community concern or media attention"; a "serious hate/bias crime" has occurred; or a "serious traffic crash" has occurred.

A single, unified definition of "critical incident" will signal to officer at the scene of a serious incident that a single on-scene supervisor should be designated, that supervisors should be notified and roll out to the scene, and that, pending the arrival of supervisors higher in the chain of command, one officer will retain centralized command and control of the scene. The definition does not compel SERT to roll out to all such incidents. SERT will continue to roll to those critical incidents to which it is already required to roll. **Recommendation 2008.2** expands the scope of **Recommendation 7.6** from the 2003 PARC report.

When supervisors of higher rank become aware of such ongoing critical incidents, they should, as set forth in **Recommendation 2008.1**, roll to the scene of such serious, unfolding situations. Cases 2 and 5 are examples of critical incidents where a mandatory rollout by a lieutenant would have occurred if a policy outlined in **Recommendation 2008.1** had been in place. In Case 5, the presence of a lieutenant may have prevented the lack of coordination between the sergeants and the passivity of personnel between the time SERT was called out and later arrived. In Case 2, there was no effective supervision once the sergeant became an actor rather than a supervisor. The presence of a lieutenant may

have prevented the situation from escalating. Likewise, in Case 9, the presence of a lieutenant would have made more likely that SERT would have been called out earlier.

The PPB has taken steps to tighten command-and-control in the context of critical incidents mandating a SERT rollout. As discussed in the introduction, command of such incidents will fall to a seasoned individual who will play the role of Incident Commander.

This role of the Incident Commander was formulated in 2006, after both cases reviewed for the present report that involved SERT occurred. The Critical Incident Commander (CIC), "responds to all emergency SERT/HNT activations" and will assume "authority and responsibility for all police actions during [the] incident once he/she assumes [command] from the on-scene incident supervisor" (PPB Policy §720.00). The CIC is a supervisor, ranked lieutenant or above, selected for the position via a formal process. Once selected, a CIC receives a 2 or 3-day training on SERT, HNT, and the bomb squad by each operation. CICs receive additional training from the National Tactical Officers Association Command School. Once trained, all Critical Incident Commanders attend ongoing, weekly SERT training and an annual out-of-town training. The PPB hopes that such close interaction and specialized training integrates the SERT, HNT, and general command operations.

The policy calls for the Critical Incident Commander to respond to all SERT activations, high-risk warrants, or other incidents as specifically directed. That CIC "has authority and responsibility for all police actions during an incident once he/she assumes command from the on-scene incident supervisor" (PPB Policy §720.00). CICs roll, then, to the scene of a subset of critical incidents specifically outlined in SERT/HNT policy and assume direct command and control from the on-scene supervisor as soon as they arrive and maintain it throughout the incident.

The role created for the CIC is excellent, and it may very well ameliorate some of the deficiencies in supervision we found in the cases we reviewed this year. Our intention in **Recommendation 2008.1** was to create a role akin to that of the CIC for on-scene supervisors to maintain explicit, unified command of critical incidents, as defined in

Recommendation 2008.2, before a CIC arrives or throughout a critical incident not involving a SERT callout. **Recommendation 2008.1** also ensures that a supervisor of a rank higher than sergeant is automatically notified for all critical incidents, as defined by **Recommendation 2008.2**.

III. Provision of Medical Care

Prior to 2005, PPB Policy §1010.10, the "Deadly Physical Force" policy, did not contain any specific directives on providing medical attention to wounded or injured suspects. This was changed in August 2005 to require a member to "continually monitor" an injured person "if tactically feasible or appropriate," with paramedics to be requested if the injury required medical attention. An officer must monitor an injured suspect and, should he or she observe changes in skin color, breathing or level of consciousness, paramedics are to be notified.

In a separate policy, entitled "Emergency Medical Aid" (PPB Policy §630.50), PPB officers are advised that they must "provide medical aid to ill or injured persons," assuming that they have been properly trained in First Aid and as a First Responder, when:

> c. Primary police duties have been accomplished.
>
> 1. Any immediate danger has been neutralized.
> 2. Dangerous subjects have been apprehended or have fled the immediate area.
> 3. Any required emergency assistance has been requested by telephone or radio, *at the earliest time feasible*. (Italics denote 2003 policy change).

The Bureau inserted the phrase "at the earliest time feasible" into §630.50 in July 2003. The remainder of the policy has been in effect since before our original report.

PARC's 2005 First Follow-Up report noted that the 2005 changes to "Deadly Force Policy" and the 2003 changes to "Emergency Medical Aid" policy were constructive. That report did, however, note instances in reviewed cases in which "medical aid could have

been rendered more promptly without unreasonable risks to officer safety" (2005, p. 60). Considering those cases generally, along with the policy changes outlined above, the 2005 report recommended that such policies be made stronger.

Recommendation 2005.7: *The PPB should clarify its policies relating to medical attention and rendering aid to make clear that officers who have used deadly force are required to ensure that medical aid is rendered to injured persons as soon as possible, unless the circumstances clearly demonstrate that to do so would unreasonably endanger the officers or the medical personnel.*

Recommendation 2005.8: *The PPB should promulgate the policies and procedures necessary to require in all instances of the use of deadly force where a person is seriously injured: an Internal Affairs administrative investigation, and an explicit determination by the Use of Force Review Board, as to whether there was compliance with the policies for ensuring that medical aid is appropriately and timely rendered.*

We continue to advocate full implementation of **Recommendation 2005.7**. Specifically, the Bureau should amend its policy such that officers are required to render aid *as soon as possible*, unless providing such aid would unreasonably endanger the officers or medical personnel providing such aid. Such a formulation is stronger and more specific than current policy that, per the 2003 change, instructs officers to render aid *at the earliest time feasible*. "Feasability" is an unclear and imprecise threshold for officer provision of medical aid.

One case from our review for this report, case 5, underscores the importance of emphasizing explicitly in policy, in training, and in administrative review the importance of rendering aid at the earliest possible juncture so long as the circumstances do not unreasonably endanger the officers or the medical personnel. Indeed, in that case, timely provision of medical care, as the coroner suggested, likely would have prevented a suspect from bleeding to death, as none of the suspect's wounds were otherwise fatal:

- *Case 5.* The suspect was shot by bullets 13 times, hit 22 times with beanbags, and tased four or five times. Although the suspect was nonresponsive, the officers and supervisors present made no effort to render medical assistance. One officer said that it appeared that the suspect was "bleeding out" and losing muscular control. About 50 minutes then elapsed before SERT showed up. Over 37 additional minutes, SERT officers fired Sage 37 mm rounds at him, had a canine bite and drag him, and employed a Taser twice before grabbing him and removing him to the street. Medics pronounced him dead. The medical examiner's office and autopsy report would later indicate that none of the suspect's specific wounds were immediately fatal.

Case 5 occurred before the 2005 changes in §1010.10. In response to this case, as well as an earlier case that occurred in 2003, the PPB, to its credit, recognized the need for improvements in policy related to medical aid. The Bureau initiated the positive policy changes that established a dedicated "Post Use of Force Medical Attention" policy as part of its broader set of policies on deadly force (§1010.10) described above. In other words, the Bureau identified a deficiency in existing policy—or the lack of specific, dedicated policy compelling officers to monitor the health and well-being of a subject injured by an officer's use of force—and addressed it. Such capacity for self-correction is notable and laudable.

Still, the case demonstrates that Bureau's current policy does not go far enough. It must yet compel officers to render aid *as quickly as possible*, unless the rendering of aid would present an unreasonable danger.

The case similarly emphasizes the importance of adherence to **Recommendation 2005.8** by ensuring that administrative review always and systematically considers, in instances in which any individual is injured, whether aid was delivered as soon as was possible without unreasonably risking injury to officers or others. At the time of case 5, there was policy (§630.50) on the books at the time requiring provision of medical care to injured persons. Much of the PPB's investigation and review of the incident failed to explore the failure to

render aid to the wounded suspect despite the policy's dictate that "members will provide medical aid to ill or injured persons" once "primary policy duties have been accomplished," to the extent that "immediate danger has been neutralized." Homicide detectives' questioning of patrol officers and the initially responding sergeant did not explore the issue. Interviews did not explore why involved officers chose particular tactics or why on-scene supervisors did not intervene when the officers' efforts transitioned from the utilization of deadly force to efforts to secure the scene—a potential indicator that the "immediate danger" to officers had, indeed, "been neutralized."

Each element of the administrative review for Case 5 should have considered officer and supervisor actions in light of the existing policy on "emergency medical aid." Instead, the Training Division report failed to include discussion of the Department's training on medical attention to wounded suspects. An After-Action Report, extensive and detailed in regard to other issues and tactics used in the incident, did not focus sufficiently on the issue of whether patrol officers reasonably acted to provide prompt medical attention to the suspect. Finally, the SERT After-Action Report did not explore why SERT failed to render medical assistance for an additional 37 minutes to a suspect who had not moved for nearly an hour.

In short, PPB must ensure that officers render aid without delay unless doing so would put them in immediate danger. Supervisors must assert their authority and control over situations in which medical aid may need to be rendered in critical incident situations, forcefully directing the provision of such assistance as Bureau policy dictates. The review of officer-involved shootings must always and systematically assess the performance of all involved officers and supervisors to consider whether aid should have been rendered earlier than it was.

CONCLUSION

Our review of officer-involved shootings identified continuing issues related to deficient supervision. Given PARC's concerns about deficient supervision expressed in 2003, 2005, and 2006, these incidents could be disheartening. The reason we are not more troubled is that Chief Sizer has spotted these problems and taken various steps to cure them, most notably by the creation of a cadre of expert Incident Commanders and the expansion of training in critical incident management provided to sergeants. The growing ability of the PPB to recognize and correct in its own shortcomings is noteworthy and praiseworthy.

2

Field Tactics

In this chapter, we examine the field tactics employed in the twelve officer-involved shootings reviewed this year. Some officer-involved shootings are avoidable, particularly when there are equally effective strategies and tactics to be employed that present lesser risks of death or serious injury to the police officer and suspect alike. The 2003 PARC Report recommended that the Bureau consider alternatives and attempt to contain unnecessary risk in high-risk vehicle stops, vehicle pursuits, foot pursuits, and situations involving use of cover, crossfire, and bystander endangerment. It also considered issues relating to accidental discharge and less lethal force options. The following chapter considers the 2003 recommendations that address each of these, as well as other, tactical areas.

Recommendation 7.8: *The PPB should ensure that field performance consistently reflects the Bureau's tactical training.*

I. HIGH-RISK VEHICLE STOPS

Our review of the Bureau's current, comprehensive lesson plan on vehicle extractions found it to present officers with a number of sound tactical options and considerations. The quality of the curriculum and training materials in this area has remained high.

Accordingly, we have no quarrel with the PPB's policies and training on high-risk vehicle stops. The essential policies and training existed at the time of our initial investigation in

2002. Nonetheless, just as in our 2003 and 2005 reports, we continue to see examples where officers disregard that training and put themselves, and others, in harm's way.

We looked, in particular, at how well the PPB identified and resolved those instances. Two cases reviewed this year involved high-risk stops. In one, we were pleased that the PPB identified problems during their internal reviews of the incidents and took corrective action. In the other, the PPB identified and corrected some but not all the problems presented.

Recommendation 2005.5: *PPB procedures should require (a) that a supervisor and sufficient cover officers be present before members try to extract an apparently unarmed person from a vehicle, and (b) that tactics calculated to protect the safety of both the officers and the occupant of the vehicle be employed.*

- *Case 6.* Suspecting that the driver of a pickup truck is intoxicated, two officers initiate a traffic stop. The officers walk to the truck, but the driver begins to drive away. An officer runs parallel to the passenger window, striking it several times with his flashlight.

- Officers return to the patrol car and initiate pursuit. The truck stops, and the officers exit their patrol vehicles and approach the truck with guns drawn. The officer who had earlier struck the passenger window of the truck opens the passenger door of the truck while holding his gun in his right hand. The officer fired a single round into the truck, claiming later that it was a negligent discharge. The round eventually lodged in the bedroom closet of a nearby residence, though neither the driver of the vehicle nor any civilians were injured.

The After-Action Report and Training Division appropriately identified problematic actions in this incident. The Bureau in this instance capably adhered to the spirit of **Recommendations 7.8** and **2005.5**.

- *Case 5.* An officer reports that he is following a truck stolen earlier that evening. When the truck crashes into a fence, the officer exits his patrol car, drawing his gun as he does so. He points his gun at the suspect, still in the truck, and orders him to comply. The suspect does not. The officer then runs up to the driver's door of the truck and grabs the suspect's nylon jacket with his left hand, while retaining the gun in his right hand. The suspect breaks away from the officer and flees on foot.

The Unit Commander's After-Action Report for the shooting considered the officer's tactics, noting that the officer "should not have approached…, particularly with his gun drawn," as "moving within arm's reach of an uncontrolled subject with your gun drawn can lead to serious consequences including having your gun taken away and a negligent discharge." The officer ultimately received an informal debriefing on the tactics used and no formal discipline. Although the PPB did take some corrective action, it missed a chance to emphasize the danger of abandoning the cover of a patrol car in favor of approaching a potentially armed suspect on foot. Doing so would have underscored the importance of adherence to **Recommendations 7.8 and 2005.5**.

Even with the high quality of training on high-risk stops that the Bureau has had in place from before the time of our initial report, it must continue to do all that it can to ensure that officers use the benefits of cover and additional officers during high-risk stops in the manner that such training dictates.

II. PURSUITS

VEHICLE PURSUITS

In the shootings reviewed for this report, the only significant vehicle pursuit occurred in Case 5. Though plagued with technical difficulties, in the main it was a well executed

pursuit. The PPB appropriately identified an issue with respect to an error in the placement of a spike strip and took appropriate corrective action.

The PPB continues to offer thorough and sound training on vehicle pursuit management in the Sergeant's Academy. The department's vehicle pursuit policy, PPB Policy §630.05, reflects well the responsibilities and duties of officers initiating vehicle pursuits, officers engaged in them, and supervisors who oversee them. Indeed, a specific policy subsection, "Pursuit Supervisor Responsibilities," delineates clearly the expectations of supervisors assuming command of a pursuit and emphasizes close communication with involved officers and ongoing, critical weighing of the risk to the public of failing to apprehend the suspect "against the danger to life and property inherent in pursuit situations" (PPB Policy §630.05). The importance of maintaining a "safe following distance" is highlighted in training as an important and sustained consideration. All pursuits require administrative assessment via an After-Action Report and further consideration by a Pursuit Review Board.

Because of the foregoing, we conclude that, in the cases we reviewed for this report, the PPB performed as hoped for in response to the two 2003 recommendations relating to vehicle pursuits.

Recommendation 7.9: *The PPB needs to take steps to ensure that supervisors consistently manage pursuits to a high standard and that officers communicate effectively during pursuits.*

Recommendation 7.10: *The PPB should ensure that its officers maintain sufficient distance when pursuing armed suspects in a vehicle.*

SHOOTING AT MOVING VEHICLES

In our initial 2003 review, officers shot at moving vehicles in four of the 30 cases considered, and the gunfire in those cases did not stop the movement of the vehicles. Accordingly, we recommended:

Recommendation 7.15:

The PPB should revise its existing policy on the use of firearms against moving vehicles. The revised policy should include a preface explaining that shooting at moving vehicles is dangerous and generally ineffective, and should embody the following guidelines:

- *Officers shall not fire at moving vehicles except to counter an imminent danger of death or serious bodily harm to the officer or another person.*
- *Officers shall only fire at a moving vehicle when no other means of avoiding or eliminating the danger it presents are available at that time.*
- *Officers shall not place themselves, or remain, in the path of a moving vehicle.*
- *Officers shall take account of risks to vehicular and pedestrian traffic, and to any other bystanders, before deciding whether to fire at a moving vehicle.*
- *Officers shall take account of risks to vehicle occupants, who may not be involved (or may be involved to a lesser extent) in the actions necessitating the use of deadly force before deciding whether to fire at a moving vehicle.*

Between PARC's 2003 and 2005 reports, the PPB revised its policy on "Deadly Physical Force" to reflect the specific dangers inherent in shooting at moving vehicles. It prohibits shooting at a vehicle unless doing so is intended "to counter an active threat of death or serious physical injury to the officer or another person, by a person in the vehicle using means other than a vehicle" and/or if "there are no other means available at the time to avert or eliminate the threat" (PPB Policy §1010.10). The policy additionally urges officers to be "mindful" that "moving to cover, repositioning, and/or waiting for additional responding" units ultimately "minimizes the necessity for use of deadly physical force" (PPB Policy §1010.10(d)). Officers who are "threatened by an oncoming vehicle should attempt to move out of its path instead of discharging a firearm at it or any of its

occupants" (PPB Policy §1010.10(d)). This policy encapsulates current practice in leading police departments. We commend the department for making this important change.

This year, we only reviewed one case involving a shooting at a motor vehicle.

- *Case 11.* Two officers shot at a motor vehicle through its back window. The PPB appropriately identified the issues at hand and took appropriate action.

FOOT PURSUITS

Recommendation 7.11: *The PPB should adopt and enforce a policy mandating the use of sound foot pursuit tactics by its officers.*

An officer's solo pursuit of a suspect on foot carries a heightened risk of death or serious physical injury to the police officer and the suspect alike. Indeed, the Bureau's policy on foot pursuits, PPB §630.15 ("Foot Pursuits"), calls them "inherently dangerous police actions." An officer giving chase on foot will have minimal reaction time if the suspect produces a weapon. The officer runs the risk that he or she will be caught in a confrontation with a suspect in inhospitable or hazardous surroundings, without backup or support. As the FBI, in a Law Enforcement Bulletin, explains, officers "engaged in such activities as foot chases…often…rush into what can be described as 'the killing zone,'" or "a "10-foot radius of the offender," out of often understandable "desire to apprehend offenders at all cost."[3] The role of a foot pursuit policy, then, is to specifically codify what the officer must consider when deciding whether to initiate or continue a foot pursuit.

The 2003 PARC Report documented instances in which officers engaged in foot pursuits of armed suspects when alternative and equally effective strategies or tactics were available. It urged the PPB to adopt a formalized foot pursuit policy, citing policies from

[3] FBI Law Enforcement Bulletin, Vol. 71, p. 1 (March 2002).

other law enforcement agencies and a model policy adopted by the International Association of Chiefs of Police (IACP).

PARC's 2005 report noted the PPB's progress in creating such a policy, commenting briefly on a draft version. It said that the final foot pursuit policy should place more emphasis on the dangerous nature of foot pursuits and public safety as the primary consideration in determining whether to initiate or continue a foot pursuit. The PPB's current foot pursuit policy, adopted in July of 2006, provides affirmative direction and guidance to officers about initiating or continuing a foot pursuit. The PPB's current policy is, by and large, excellent.

The 2005 report also recommended that the optimal foot pursuit policy ought in general to prohibit solo pursuits. It also suggested that foot pursuits terminate when partners split and lose sight of each other. The report also suggested that if the identity of a suspect is known, and the suspect is not posing an immediate threat to others, police officers should consider terminating the foot pursuit in favor of later apprehension. These recommendations have not been made part of the PPB's pursuit policy, §630.15. We continue to believe that those recommendations are of high importance and again urge their incorporation into PPB's foot pursuit policy.

One of the twelve shootings reviewed this year underscored the potential dangers of pursuing a suspect alone. While the case occurred prior to the adoption of the current foot pursuit policy and prior to our 2005 recommendations, the factual pattern points out the heightened risk to police officers when partners split. Adoption of our 2005 recommendations might, in the future, prevent the splitting of partners described in that case.

- *Case 4.* Two officers in a marked patrol car are searching for an armed robbery suspect. They see him on a light rail transit platform. The officer in the passenger seat exits the patrol car and initiates a foot pursuit. The other officer continues driving toward a nearby street to cut off the suspect's potential escape

route. The officers do not maintain constant sight of one another. Neither officer broadcasts the pursuit. One of the officers eventually encounters the suspect and confronts him without benefit of a partner to back him up.

The officers sacrificed their numerical advantage against an armed suspect. The officer who gave chase on foot would have had no backup if the suspect had stopped and ran toward the officer as he rounded a corner, setting up the possibility of an ambush. Later, when one of the officers confronted the suspect, he could not utilize the cover of a partner. Both officers placed themselves at much higher risk because they elected to each pursue the suspect alone.

III. USE OF COVER

The 2003 PARC report found numerous instances in which officers failed to use effectively the cover that was available to them, which placed them at a higher risk than necessary in those incidents. It found that the failure to utilize cover as a tactical option was not cited or considered in administrative review.

Recommendation 7.12: *The PPB should ensure that officers make appropriate use of cover when confronting threats.*

The PPB states that it considers the use of cover to be "a basic and critical [tenet] of officer training." "Cover and concealment" is highlighted as one of five "tactical advantages" that are taught in a Patrol Tactics course at the academy, advanced academy, and yearly officer in-service training. On the whole, such training appears sound.

Our review of officer-involved shootings for the present report revealed instances in which officers either failed to take available cover or affirmatively abandoned cover and placed themselves at risk of death even though safer options were available. During the review

process, the PPB appropriately spotted a problem in one instance and was less successful in another.

- *Case 12.* Four officers respond to a call of a man with a knife walking back and forth outside a hotel. The first arriving officer leaves his patrol car and immediately approaches the man, without waiting for the other officers that he knows are responding.

The Training Division review in Case 12 criticized the officer's tactics and considered changes to its training in light of the incident.

- *Case 5.* Officers pursue a stolen vehicle which ultimately crashes into a fence. An officer abandons cover and runs to the driver's door of the truck.

By abandoning the protection of cover and acting alone, these officers endangered themselves and preempted a coordinated approach by all officers present to take the suspect into custody. The Training Division's analysis in Case 5 did not consider whether the officer's performance was inconsistent with his training. The PPB ultimately found no policy violation in the approaching officer's actions in that case.,.

IV. CROSSFIRE AND FAILURE TO CONSIDER BACKDROP

Officer-involved shootings unfold quickly, compelling officers to make instantaneous appraisals of situations and decisions. Always present is the risk that an officer who shoots at a suspect may put other officers or bystanders at risk of "friendly fire" or ricochets. The 2003 PARC Report addressed this concern, noting instances in which officers endangered other officers at the scene because they ignored the potential for crossfire or failed to consider backdrop.

Recommendation 7.13: *The PPB should ensure that the incidence of crossfire is minimized*.

The PPB considers the minimization of crossfire as "a basic and critical [tenet] of officer training" in regard to firearms, with appropriate training appearing as part of both academy and in-service programs. Crossfire is also discussed in other appropriate training modules (for example, that regarding "High-Risk Traffic Stops"). The Training Division's post-shooting review is to consider the extent to which involved officers properly minimized the possibility for crossfire.

The Training Division correctly spotted a failure to consider backdrop in the following case:

- *Case 8.* Officers respond to a domestic violence call. The officers encounter the suspect in a fetal position on the kitchen floor holding a knife and mumbling. The suspect stands, yells, and charges the officer, coming within five to eight feet. An officer in an adjoining room fires six shots through the wall without knowing the positions of the officer or the suspect.

While it notes that "it is difficult to criticize" the shooter "because this was a successful tactic," the Training Division appropriately noted that "the practice of shooting blindly through a wall is questionable."

V. BYSTANDER ENDANGERMENT

Poor coordination or communication among officers in an unfolding critical incident may endanger persons who happen to be nearby. PARC's 2003 Report recommended that the Bureau afford special attention to such concerns.

Recommendation 7.14: *The PPB should ensure that the incidence of bystander endangerments is minimized.*

We commend the Bureau for its notable progress toward this recommendation. The PPB recently commented to us that it considers a minimization of danger to bystanders as "a basic and critical [tenet] of officer training" that is stressed in firearms instruction materials used in academy and in-service training. Appraisal of an officer's "target and backstop" is presented as one of the "cardinal rules of firearms," with the Training Division charged with reviewing whether officers have minimized risk to bystanders when employing their weapons and "adjust[ing] training regiments." The training has paid off: In none of the twelve cases were bystanders put at risk. Indeed, in two cases, officers laudably handled bystander safety issues:

- *Case 4.* An officer involved in securing a fleeing armed robbery suspect, holds fire. The officer later notes that, at the moment, he was "looking" and "thinking people."

- *Case 10.* An officer encounters a man with a knife where there are other people present. The officer formulates a plan to get the bystanders out of the way while holding the suspect at bay with her gun but the suspect does not comply and comes within five or six feet from one of the bystanders. When the suspect raises the knife to shoulder level, the officer fires one round at the suspect. No bystanders are injured.

VI. ACCIDENTAL DISCHARGES

Accidental discharges often result from officers failing to keep their finger outside the trigger guard of their weapon until they intend to fire. Indeed, "accidental discharges" may more accurately be referred to, as the PPB does in its deadly force policy, as "negligent"

discharges, as they can be avoided when officers exercise appropriate gun handling techniques.

The 2003 Report found four incidents in which officers unintentionally discharged their weapons. The Report recommended that the PPB attend more closely to training officers in firearms handling such that accidental discharges rarely, if ever, occur.

Recommendation 7.16: *Given the considerable danger that arises from accidental discharges—and their avoidability with due care—we recommend that the PPB pay closer attention to the issue in its training, field operations, and shooting review process*.

The PPB has responded well to this recommendation. The PPB's current training features a strong, clear directive, instructing officers, as one of the four "cardinal rules of firearms" articulated in both academy and yearly in-service training, to "never put your finger on the trigger until you are on target and ready to fire." The training explains that, despite "TV, theaters, pictures, [being fascinated] with having their finger on the trigger…, if you fire a round it better be on purpose and in the direction you intended." By policy, negligent discharges are investigated in the same way as an officer-involved shooting or in-custody death, with Homicide detectives conducting the factual investigation and the Training Division doing an analysis. The PPB reports that, in the past three years, there have been five cases in which the Performance Review Board has issued sustained findings against an officer for negligent discharge.

PARC congratulates the PPB on its rigorous training materials aimed at minimizing negligent discharge. Two of the officer-involved shootings for the present report illustrate the PPB's analytical approach to negligent discharges:

- *Case 6.* After a driver speeds away from an initial traffic stop, two officers give chase. The vehicle stops and one officer fires a single round into the vehicle. The officer claims the firing to be an accidental discharge.

- *Case 7.* During the search of a residence an officer accidentally fires a gun into the floor due to clutter, an awkward position, and attempted use of a flashlight attached to the gun.

The Bureau ably identified deficiencies in the involved officers' tactics. The Training Division, in its review of Case 7, recommended the development of a new class to address the handling of "lighted Glocks" in common situations. The investigation and administrative reviews in both negligent discharge cases were rigorous and thorough. They underscore the extent to which the PPB takes firearms handling seriously and revises its training practices in response to issues arising from shooting incidents.

VII. FORCE OPTIONS

Under the Bureau's newly revised policy on "Physical Force" (PPB Policy §1010.20), officers are instructed to "use only the force reasonably necessary under the totality of circumstances to perform their duties and resolve confrontations effectively and safely." Officers must assess the circumstances and determine what method or level of force is reasonably necessary to meet law enforcement objectives while ensuring the safety of officers and civilians. We turn now to consider three force options—the Taser, the beanbag shotgun, and the AR 15 assault rifle.

TASERS AND BEANBAG SHOTGUNS

Less-lethal weapons such as beanbag shotguns and Tasers can subdue suspects in circumstances where police officers otherwise might have had to shoot the suspect. The Taser is a weapon that releases a high-voltage, low-amperage electrical charge to the suspect, causing him briefly to lose muscle control and drop to the ground. A beanbag shotgun is designed to stun or otherwise temporarily incapacitate a suspect or dangerous individual so that law enforcement officers can subdue and arrest that person with less danger of injury or death for themselves and others. The beanbag is usually fired from a

12-gauge shotgun. Tasers and beanbag shotguns are used by PPB officers. In PARC's 2003 Report, we recommended that the Bureau closely monitor their use:

Recommendation 7.19: *We encourage the Bureau to carefully monitor and evaluate the effectiveness of all its less-lethal hardware, and to tailor the availability and deployment of such weaponry to ensure that operational personnel have ready access to the most effective and appropriate options when called upon to use force.*

TASERS

All uniformed officers and sergeants must carry a Taser. Per PPB policy, Section 1051.00 "Taser, Less Lethal Weapon System," the Taser may be used when "a person engages in or displays the intent to engage in": "physical resistance" or actions that attempt to prevent an officer from controlling the subject but do not attempt to harm the officer; "aggressive physical resistance," or "physical actions of attack or threat of attack"; or suicidal behavior. Tasers are not to be used on children, individuals over age 60, pregnant women, individuals who are "medically fragile," handcuffed suspects, individuals engaged in passively resistive behavior, or subjects who have come in contact with or are located near flammable substances. Officers are instructed to consider carefully deployment of the Taser when individuals are standing in or near a body of water. Officers are to give suspects verbal warning before using the Taser, and PPB policy contains specific post-deployment medical procedures. If "feasible," members using the Taser "should be supported by at least one officer capable of providing immediate cover."

The PPB represents that it "carefully and closely monitors and evaluates the Taser program." The use of a Taser requires the completion of a Use of Force Report. Any use of the Taser that involves six cycles, or firings, of the Taser, or where the Taser appears to have been used in a circumstance that is generally prohibited by PPB policy, requires completion of an After-Action Report, or a formal supervisory review.

The PPB is currently developing an early intervention system, or EIS.[4] It will be used to track and monitor Taser usage. Thus, an early identification system will be able to track continually when and how often Tasers are by specific officers.[5] We commend the PPB for taking the initiative to develop an early intervention system.

- *Case 5.* The repeated use of the Taser on a nonresponsive suspect was questionable. The suspect had already been shot 13 times and hit 22 times with a beanbag before being tased repeatedly by two different sets of officers at different times.

Some jurisdictions have found that an upper limit on the number of times that an officer may cycle the Taser will reduce the unsuccessful usage of the Taser. For example, the NYPD has determined to limit the number of times a Taser may be fired to three.[6]

Recommendation 2008.3

PPB policy should dictate that when a Taser is used against a subject it shall be for one standard discharge cycle and the member using the Taser must then reassess the situation. Only the minimum number of cycles necessary to place the subject in custody shall be used. The Bureau should strongly advise officers against using more than three standard discharge cycles against any subject such that, if the third cycle does not make contact or is ineffective, the officer considers other options. The

[4] An early intervention system, also referred to as an early warning system, "is a data-based police management tool designed to identify officers whose behavior is problematic and provide a form of intervention to correct that performance." (Walker, Samuel; Alpert, Geoffrey P.; and Kenney, Dennis J., "Early Warning Systems: Responding to the Problem Officer," National Institute of Justice: Research in Brief, July 2001, 1).

[5] To make best use of a computerized database for tracking uses of force, the Department should ensure that the Use of Force Reporting Form records how many times a Taser is cycled when it is used on a given incident.

[6] "When a [Taser] is used against a subject it shall be for one (1) standard discharge cycle and the member using the [Taser] must then reassess the situation. Only the minimum number of cycles necessary to place the subject in custody shall be used. In no situation will more than three (3) standard discharge cycles be used against any subject. Officers are reminded of other appropriate force options should the [Taser] fail." (NYPD P.G. 212, Interim Order 20 (June 4, 2008)).

Bureau should automatically, systematically, and critically examine instances in which the Taser has been cycled for more than three standard cycles.

BEANBAG SHOTGUNS

Current Bureau policy dictates that "only those members currently certified" to use them "are authorized to deploy [beanbag shotguns]" (PPB Policy §1050.00). The Training Division provides the initial and ongoing certification of officers in the "proper use and deployment" of these shotguns. Officers request and complete applications for certification from their supervisors, and they complete a training course. Certified officers must requalify three times a year. Officers who have qualified to carry and use less lethal shotguns carry them in their patrol vehicles.

Officers who fire a beanbag round complete a Less Lethal Munitions Database Report and a Special Report that "contain[s] the specific circumstances that led to the discharge of the weapon" and information about the supervisor who has been verbally notified of the use of the less lethal weapon, which policy dictates should occur "as soon as practical" (PPB Policy §1050.00).

Like the Taser, the PPB does not monitor less lethal shotgun use statistically or in aggregate. The full implementation of a comprehensive early intervention system will allow the Bureau to fully monitor trends in the less lethal shotgun use.

- *Case 5.* A suspect was hit with 22 beanbag shotgun rounds. Further beanbag rounds were fired by SERT officers approximately one hour later.

The very large number of beanbag volleys raises concerns that the current PPB policy is not sufficiently narrow. We offer for the PPB's consideration the following elements of a

model policy regarding beanbag shotguns based in significant part on current scholarship regarding impact munitions.[7]

Prohibitions and Cautions

- Beanbag rounds may only be used to subdue or incapacitate an individual engaged in active aggression, aggravated active aggression, to prevent imminent physical harm to the officer or another person, or to prevent individuals from threatening or committing suicide or otherwise injuring themselves or others.
- It is prohibited to use beanbag rounds on persons as a form of coercion or punishment or for retaliation.
- Beanbag rounds should not be used when the suspect is visibly pregnant, elderly, very young, visibly frail, or disabled unless deadly force is the only other option.
- Beanbag rounds should not be used when the suspect is in an elevated position where a fall is likely to cause substantial injury or death.
- Beanbag rounds should not be used when the suspect is in a location where the suspect could drown.
- Beanbag rounds should not be used when the suspect is operating a motor vehicle and the engine is running or is on a bicycle or scooter in motion, absent overtly assaultive behavior that cannot be reasonably dealt with in any other safer fashion.
- Beanbag rounds should not be used when an individual is handcuffed or otherwise restrained.
- It is prohibited to use beanbag rounds against a crowd unless the officer has the approval of a supervisor and can target a specific individual who poses an immediate threat to cause imminent physical harm; and reasonably assure that other individuals in the crowd who pose no threat of violence will not be struck by the weapon.
- Officers are cautioned that the target area for a beanbag round substantially differs from a deadly force target area. Instead of aiming for the center mass of the body, beanbag shotguns are aimed at the abdomen, thighs or forearms. The head, neck, and groin should not be targeted.
- Officers are further cautioned that targeting the chest has on occasion proven lethal when beanbag round is fired at a close range of less than 21-30 feet.
- Officers are further cautioned that the accuracy of the rounds decreases significantly after approximately 50 feet and their flight becomes erratic, striking objects to the right, left, or below the target, increasing the risk to innocent bystanders.

Tactical Considerations

- The optimal distance for a beanbag is between 21-50 feet. Accuracy drops off rapidly after 50 feet, and 80 feet appears to be a maximum functional range. The beanbag rounds present a risk of death or serious physical injury at less than 10 feet when fired at the chest, head, neck, and groin.

[7] This model policy is a combination of considerations from several sources, including the NYPD, LAPD, LASD, and Department of Justice (Hubbs, Ken and Klinger, David, "Impact Munitions Use: Types, Targets, Effects," U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, October 2004).

- Officers should also be prepared to employ other means to control the individual — including, if necessary, other force options consistent with agency policy—if the individual does not respond sufficiently to the beanbag and cannot otherwise be subdued.

Verbal Warnings

- In cases in which the distance between the officer and the target makes it practical, and unless it would put an officer or any other person at risk of death or serious physical injury, a verbal announcement of the intended use of a beanbag round shall precede the firing of the round in order to:
    - Provide the individual with a reasonable opportunity to voluntarily comply.
    - Provide other officers and individuals with a warning that a beanbag round may be deployed.

Operations

All shotguns firing beanbag rounds must be painted in a bright color clearly and instantly distinguishable from a shotgun firing live rounds.

Handling Suspects after Deployment

- Officers should take advantage of the window of opportunity while the subject is under the effects of the beanbag to handcuff and take the subject into custody.
- Officers shall notify a supervisor that the beanbag has been deployed.
- Officers shall have medical personnel examine any suspect that has been stunned by a beanbag as soon as it can be done safely.
- Officers shall transport or arrange transport immediately to the emergency room of the nearest hospital if an individual who has been hit with a beanbag round is unconscious, complaining of pain, demonstrating difficulty breathing, or exhibiting signs of severe stress, excited delirium, hyperventilation, high temperature, or is under the influence of controlled substances or alcohol.

Recommendation 2008.4

The PPB should devise a more specific policy on beanbag shotguns and impact munitions consistent with the foregoing.

"LETHAL COVER"

The 2003 PARC report recommended against the PPB's use of the term of "lethal cover" in its training and policies on less-lethal force options.

Recommendation 7.18: *The PPB should abandon the term "lethal cover" in its less-lethal training and directives and make explicit that officers should use whatever force option is appropriate to cover officers deploying less-lethal weaponry.*

The PPB has, in its policy directives and training, indeed abandoned the term "lethal cover." Instead, the Bureau uses the term "immediate cover," defined in its Taser policy (PPB Policy §1051.00), as "a member who stands ready to deploy additional control **if needed**" (emphasis supplied). This change emphasizes the extent to which a cover officer need not always or necessarily draw a firearm to provide effective cover to an officer employing a Taser, less lethal shotgun, or other less than lethal force option.

AR-15

Currently, there are 140 AR-15s in use within the PPB. The Training Division selects officers for AR-15 training based on an officer's record of tactical maturity and sound decision-making. Ten officers go through a 50-hour operator's course at a time.

Two officer-involved shootings reviewed for this report involved an AR-15 urban police rifle, essentially the civilian model of the military's M16 high-powered assault rifle.

- *Case 3.* A suspect holding a hostage around the neck at knife point was hit with a single shot from an AR-15, striking and killing the suspect without injury to the hostage.

The above case is reflective of the sort of instance in which the use of an AR-15 by a trained, skilled officer can significantly aid law enforcement.

- *Case 8.* Following a shooting at a residence, an involved officer uses the AR-15 to clear a house. At one point, the officer needs to sling the AR-15 rifle in order to climb a staircase of the house.

The Training Division's superior analysis of the above shooting noted that AR-15 training "does not include the use of this weapon as a clearing tool"; instead, "it was adopted as a high-powered standoff weapon to be used to give officers the tool to address a deadly threat from a distance but with accuracy." Training noted "a[n] increasing trend with the PPB for officers to use the AR for clearing purposes…contrary to information taught" in the Operator's Course. It noted that "if the PPB decides that the AR is not an appropriate weapon for officers to use for clearing, then it should develop a policy that states as much."

The Training Division assembled a committee to evaluate the use of the AR-15 for clearing. In April 2008, the Training Division issued an "inter-office memorandum" that summarized that committee's recommendations. It advised that, while "the rifles should be allowed to be taken into buildings," the AR-15 should "only be used for active shooter incidents or as a long cover tool." The memo noted that "the configuration of the rifle, specifically the length, does not lend itself to being an effective tool for dynamic entries or as a slow clear tool." It noted that officers using AR-15s in such circumstances "are more likely to telegraph their movements than they would with a handgun" and "are…limited in their flexibility to assist other officers….or take a suspect into custody." The memo concludes with an advisory that "the Training Division strongly discourages the use of the rifles for dynamic entry…or slow clears," but indicates that "if the rifle is used, the operator or supervisor must be able to articulate the facts that were present to justify the increased risk associated with the use of the rifles."

We commend the Bureau and the Training Division for proactively addressing a problem of emerging concern. We concur with the assessment that performing a dynamic entry or a clearing a room with an AR-15 should be discouraged. The Bureau should codify the conclusions of the committee in policy. Officers who inappropriately use the rifle and cannot "justify the increased risk associated with the use of the rifles" receive remedial training or discipline as appropriate.[8]

[8] This is consistent with the policies of many other departments. For instance, the LAPD, which also restricts the use of urban police rifles (UPRs) to "specially trained field officers," notes that such rifles "should not be

Recommendation 2008.5

The Bureau should create a policy relating to the use of the AR-15 that approves its use where a precise, high-powered firearm is necessary and discourages its use during dynamic entry and slow clears.

VIII. ADDITIONAL FIELD TACTICS

The previous chapters have focused on those recommendations most directly relevant to the twelve shootings examined for this report. Chapter 7 of the 2003 PARC report made some other recommendations on other specific field tactics, policies, or procedures, including: **Recommendations 7.2** and **7.20**, which concern officer communications; **7.17**, which involves weak-handed shooting; **7.21**, which involves the establishment of a helicopter unit; and **7.22** and **7.23**, which concern CIT training. The Bureau's responses and progress in relation to these recommendations can be found in Appendix B, along with the PPB's complete response to how it has or is implementing the whole of the PARC recommendations within the scope of this report, or Chapters 5 and 7 of the original 2003 report.

We conclude this chapter with a brief discussion of a training device whose implications may not be as well understood within the PPB as should be.

21-FOOT RULE

The PPB trains its officers in the "21-foot-rule." Apparently originating in a March 1983 article in *SWAT* magazine, the rule, as described by the PPB Training Division in an

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deployed indoors because of the weapon's penetration capability" (LAPD Manual, 556.90 "Use of the Urban Police Rifle and Shotgun Slug"). The Seattle PD's policy states that any officer deploying such a rifle "will be responsible for justifying his/her decision to deploy with a rifle in any given set of circumstances" (Seattle PD Manual, "Chapter 070 – Rifle Policies & Safety").

administrative review, states that "a person with an edged weapon can attack an officer from 21 feet or closer and that the average officer with average human reaction time will [not] be able to draw their weapon and fire one shot by the time the attacker gets to them." In other words, permitting a suspect with an edged weapon to come closer than 21 feet may not leave the necessary time for an officer to draw and fire his or her weapon in defense.

The 21-foot rule is merely a training device to heighten an officer's perception when he or she is at heightened risk. It does not mean that a shooting that takes place within 21 feet is justified per se. The shooting must pass a normal constitutional test that the officer reasonably perceived an imminent threat of death or serious bodily injury. Also, if the officer has already unholstered and pointed the firearm, the 21 foot rule is no longer applicable. The 21-foot rule was cited in the Training Division review of two cases in which officers confronted suspects with edged weapons, and the rule was applied incorrectly in both.

- *Case 4.* Two officers pursue an armed robbery suspect. Officer 1 challenges the suspect from 25-30 feet away and had his weapon drawn before the suspect comes within 21 feet. Officer A stands his ground with weapon drawn as the suspect approaches to 10-12 feet. Officer B fires at the suspect four times.

The Training Division's analysis justified the officer's use of lethal force in part because the suspect was less than 21 feet away from Officer A when Officer B fired. Both officers, however, had already drawn and pointed their weapons before the suspect came within 21 feet. In Case 4, the 21-foot rule was misapplied as a justification for the shooting. If the shooting was in policy—as it appears to be—it was because Officer B reasonably concluded that there was an imminent threat of death or serious bodily injury to Officer A.

- *Case 12.* The unit commander who completed the After-Action Report stated: "The PPB Training Division teaches the twenty-one (21) foot rule when dealing with persons in possession of a knife. An aggressive person within twenty-one

(21) feet of you, who is armed with a knife, can attack you before you have time to fire a gun even if the officer has already drawn a gun from its holster." This is a misstatement of the rule.

Recommendation 2008.6

The PPB should clarify the 21-foot rule, emphasizing that it does not per se justify any shooting when the suspect is less than 21 feet away and is not applicable if the officer already has his gun drawn and pointed.

3

Internal Investigation and Administrative Review

This chapter reviews the status of recommendations made in PARC's 2003 Report relating to the quality of the PPB's investigation of twelve officer-involved shootings. One of the shootings occurred in 2002, before the publication of the original PARC Report. One of the cases occurred in late 2003, four took place in 2004, and six happened in 2005. The cases capture, then, the PPB in the midst of implementing many of the PARC recommendations regarding internal investigation and review.

The PPB has achieved a clear and notable increase in quality and thoroughness of its internal investigations. The quality and care taken in documentation have increased. Interviews with officers and witnesses are generally more objective and comprehensive. The preservation of the crime scene and procedures for the collection of evidence have improved. Homicide investigations were consistently improving.

The Internal Affairs (IAD or IA) investigations, while clearly better, did not improve as much. Based on the cases reviewed, the PPB has not yet ensured that the Internal Affairs investigations focus not just on what happened at the moment that an officer used force but also on what events led to the use of force and why officers made the decisions that they did. Our review found few instances where IAD added much substance to the review process; IAD relied almost exclusively on the Homicide investigation and reached few, if any, helpful or direct conclusions about the conduct of involved officers. The Training Bureau's reviews varied in quality, with some thoughtfully analyzing officer conduct and others leaving important tactical issues unaddressed, including the actions or tactics of involved supervisors, as noted in Chapter 1. Unit Commander's After-Action Reports have increased in quality, substance, and usefulness.

The latest administrative review completed in the officer-involved shootings that we were able to consider for this report concluded in mid-2006. It may very well be that the lingering deficiencies have been eliminated or diminished in the intervening years as a result of greater institutionalization of the changes and reforms made in the wake of the 2003 recommendations and the steady commitment to such changes by Chief Sizer and her team. The increased involvement of the Independent Police Review Division (IPR) in the administrative review process and IA's commitment to hiring civilian investigators—including some retired Homicide detectives—to conduct IA investigations may, in particular, have already addressed some of the improvements that we advocate below.

I. CURRENT PPB ADMINISTRATIVE REVIEW PROCESS

The current administrative review process was established when the Use of Force Review Board (UFRB) replaced the Bureau's Review Level Committee. PARC's 2006 Second Follow-Up Report focused extensively on the procedures that the Bureau implemented in July 2005 for the review of officer-involved shootings. The present report does not yet follow up on the 2006 recommendations relating to the UFRB or evaluate that body's efficacy. Instead, we consider the quality of the investigation and internal reviews presented to that Board, providing it with the raw information and detailed analysis that its members use to make a formal recommendation to the Chief of Police.

The internal review process remains as we described it in 2006. As then, the task of completing the factual inquiry into the events surrounding such a shooting falls to the Homicide. A Homicide lieutenant and commander generally respond to the scene of all officer-involved shootings. They receive an initial briefing by local command and oversee the collection of evidence and initial interviews.

Representatives from the offices of the District Attorney and City Attorney roll as well to the scene of officer-involved shootings, and Training almost always does also. Homicide

almost always conducts walkthroughs of the scene. The shooter and witness officers are segregated at the scene. Witness officers are interviewed on the day of the shooting, with interviews audiotaped and transcribed. Officers who use lethal force generally do not give statements immediately, but their union representative usually makes the officer available within 24 hours for an audiotaped interview, at which two Homicide investigators, the involved officer, and a union attorney are present.

Homicide's current goal is to complete their investigation within 30 days. Upon completion, Homicide gives the case file, or "book," to both IAD and the Training Division and meets, within two weeks of delivering the case file, with both divisions to discuss issues and concerns. Homicide, Training, IAD, and the involved officer's unit Commander will ultimately make presentations to the UFRB.

The Training Division confirms that, in the most recent officer-involved shootings, Homicide investigators have given both Training and IAD advance briefings, providing a walkthrough and updates on the investigation's progress prior to the formal submission to them of the completed case file. Training must, within 30 days of receiving the file, complete a review that, at present, apparently includes a decision point analysis in which all officer actions and tactics leading up to the use of force are methodically considered and analyzed in light of PPB policy and training. The Training review considers whether involved officers acted according to their training and whether there is a need for changes in policy and training. Training summarizes its findings in a memorandum and makes a presentation to the UFRB.

IAD examines whether the shooting was within policy and considers the officer's tactics and decision-making. Formerly, the IA investigation focused exclusively on whether the use of deadly force was in or out of policy. Since the period covered by PARC's 2006 follow-up, IA has expanded the scope of their investigation to a wider investigation of the performance of involved officers.

IA states that, at present, it almost always conducts a second, compelled interview with the shooter to ask the officer questions related to administrative policy matters, a practice that we support. IA continues, however, to rely on Homicide to establish the basic facts, a practice we continue to question. The basic facts to decide whether the shooter has violated the criminal law differ from the basic facts to decide whether a given shooting was in policy. A Homicide investigation probes the officer's state of mind at the moment he fires to determine whether the shooter had a reasonably objective perception of an imminent threat of death or serious physical injury to himself or others.

A determination that a given shooting is "in policy" means more than merely that the officer did not run afoul of the criminal law. It also reflects a judgment that the officer acted consistent with the Bureau's policy and training and did not commit unreasonable strategic or tactical errors. A shooting can be "out of policy" even if it does not give rise to possible criminal liability. IA, then, should conduct additional investigation and interviews as necessary to answer the broader questions that an administrative investigation requires. Within six weeks of receiving the case file from Homicide, IA must complete a summary report and presents its conclusions to the Use of Force Review Board at the same time as Training and Homicide do.

The external Independent Police Review (IPR) office is part of City Auditor Gary Blackmer's jurisdiction, and its current Director is Mary-Beth Baptista. IPR is involved as the IA pursues its investigation. IPR receives the case file from Homicide and makes suggestions about issues or topics to consider during the IA investigation. IPR also reviews IA's ultimate summary report and makes comments or suggestions.

After the Review Board Coordinator receives the Homicide, Training and IA reports, the coordinator forwards them to the involved officer's Unit Commander. The Unit Commander must complete an After-Action Report within 14 days that addresses the

whole of the officer's actions and tactics.[9] The Unit Commander makes a presentation to the Use of Force Review Board, as well.

The Use of Force Review Board evaluates all officer-involved shootings and serves in an advisory role to the Chief of Police, who retains final authority in determining whether a shooting, or an involved officer's actions or tactics, was in or out of policy. Per PPB Policy §335.00, "Use of Force Review Boards," the UFRB is composed of 13 members—eight voting members (including the three Branch Chiefs, two peer members of the same rank as the involved officer selected from a pre-approved pool, two citizen members selected from a pre-approved pool, and the involved officer's unit Commander sitting as the employees' Responsibility Unit manager [10]) and five advisory members (the Review Board coordinator, a representative from the Bureau of Human Resources, a representative from the City Attorney's office, the IAD manager, and the IPR Director). Board members meet to hear presentations from Homicide, IA, and Training, and, after discussion and deliberation, the Board issues a recommendation to the chief that the shooting was "in policy," was "out of policy," or is considered "in policy with debriefing," which might include "tactical development," "organizational review," or "performance analysis." The Chief of Police is charged with reviewing and evaluating the UFRB's recommendations and signs off on an ultimate finding and discipline, as warranted.

II. HOMICIDE INVESTIGATIONS

Homicide investigations have markedly increased in quality, especially in the more recent investigations. Two investigations in particular were superlative.

[9] In PPB directives, this report is not called an After-Action Report, but, rather, an "analysis and proposed finding" report in attempt to distinguish this report from those that might be required in other contexts. In our discussion with PPB personnel, communications about incidents from Unit Commanders were commonly referred to as After-Action reports.

[10] The PPB has what is called a "Responsibility Unit" or RU. Each subordinate employee has an RU manager. As a general rule, the RU manager is the same as the unit commander.

- *Case 10.* The investigation of a shooting in which an officer fired at a man coming at the officer with a weapon was thorough, careful, and of high quality. The investigators probed officers on the scene specifically as to their decision making processes. The investigators did not lead and were respectful of all witnesses, and their questions evidenced a commitment to going beyond superficial, obvious questioning in order to address all potential areas of concern, inquiry, or complication. The evidentiary inventory and case file was well-organized and complete.

- *Case 8.* The investigation of a case in which PPB officers fired at a man who charged at them with a knife was straightforward, professional, and reached reasoned factual conclusions about complicated circumstances. The questioning of involved officers was thoughtful.

DOCUMENTATION OF THE INVESTIGATION

Recommendation 5.14: *All records, documents, and materials obtained or created in connection with an investigation of an officer-involved shooting or an in-custody death should be made, and should remain, a part of the official PPB file.*

The PPB states that it has responded to the 2003 recommendation to preserve all documents and materials related to an officer-involved shooting investigation by preserving the official files on officer-involved shootings locked in the office of the captain of the Records Division. Detective notebook files are also in the Records Division. Original photography and videography are stored in the Identification Division, and original IA and Training reviews are maintained by the respective divisions. The Review Board Coordinator "maintains copies" of the various reviews and summaries presented to it and "stores them as a single file, allowing for convenient review by Peer and Citizen Members of the Board and others," according to the PPB. Assuming that the file in the

Records Division truly is complete, the PPB has achieved what our 2003 recommendation contemplated.

The case files for the twelve shootings reviewed this year were generally more complete and better organized than similar files reviewed in the past. Evidence and materials referenced in reviews and summaries by detectives, Training, IA, and Unit Commanders could usually be accessed readily.

We nonetheless came across a few instances in which referenced reports or transcripts were apparently not included or preserved as part of the official PPB file.

- *Case 5.* Investigators recorded interviews with responding SERT officers. Although the case file includes summaries of the interviews, the transcripts and audio recordings of the interviews were missing.

  Homicide case file was missing multiple pages of materials. Pages of multiple written reports, one from a criminalist and one from a sergeant, were missing.

  Further, no crime scene video was provided, and neither the videotape nor the transcript of officers firing beanbag rounds at the suspect was included as part of the investigative file. In the same case, autopsy and toxic exam reports were missing from the case file.

- *Case 4.* The interviews of some civilian witnesses were provided in transcript form alone. The audiotapes of interviews of other civilian witnesses were provided without accompanying transcript. For at least one witness, only a summary, and no transcript or audiotape, was provided.[11]

[11] While the scope of the present report does not address the specific recommendation, the case points out the continuing importance of **Recommendation 4.12** of the 2003 report, which called for "all civilian witnesses" to be "interviewed on tape whenever possible," with "transcripts of all interviews…included in the case file." All witness interviews should have been tape recorded and transcribed, with both audio tapes and interviews included in the case file. Our discussions with Homicide for this report suggest that investigators have made

Recommendation 5.11: *The investigative file for an officer-involved shooting or in-custody death should include all relevant evidence and information, including, without limitation, (a) color copies of pertinent crime scene photographs; (b) all videotapes taken of the scene; (d) all autopsy, toxicology, and medical reports obtained by investigators (or a memorandum explaining why it was impossible to obtain such reports); (e) transcripts and audiotapes of all 911 calls and radio broadcasts (as well as relevant MDT transcripts); and (f) a memorandum presenting in summary fashion certain background information on the involved officers, including (i) date of hire and prior law enforcement experience; (ii) training history; (iii) assignment and promotion history; (iv) prior shootings or in custody death cases, if any; and (v) a record of any discipline, pending investigations, and awards or commendations.*

With the exceptions noted above, the investigative files included the specific information that **Recommendation 5.11** addresses. The PPB reports that "all crime scene photographs and videos are taken and stored by the Identification Division," with copies of those photos deemed "useful" included in the Detective's notebooks. (The Bureau notes that "many of the typically hundreds of photos taken of the scene are not useful"). Video is taken of the scene at every officer-involved shooting. Medical reports, audiotapes of 911 calls and radio broadcasts, and transcripts of such calls and broadcasts are to be always included in the case file.

The PPB took an approach to gathering the information contemplated by **Recommendation 5.11(f)** different from the single memorandum that the recommendation proposed. The PPB currently uses an "interview checklist" that requires investigators to make specific inquiries into the officer's background, including training, prior law enforcement and military experience, other prior employment, involvement in other deadly force incidents, and current assignment. The checklist does not specifically call for the

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progress, in the four years since investigating this case, toward ensuring that this is now standard practice; our review of case files of later cases suggests this to be the case.

officer's prior disciplinary history or pending investigations or force incidents other than deadly ones.

In the future, however, when the PPB has a fully functional early intervention system, the additional information should be readily available. The early intervention system will also collect information relating to civil liability, civilian complaints, and the like. In 2005, PARC recommended that the PPB set a date certain by 2007 for the full implementation of the early intervention system. It is disappointing to report that the system is still not fully implemented.

Recommendation 5.12: *Each investigative file should contain a detailed, comprehensive summary of the investigation. Although the summary should be impartial and take a neutral tone, it should also identify inconsistencies between statements and inconsistencies between statements and physical evidence.*

The PPB reports that, "in practice, the investigative report includes a summary with the following sections: incident chronology, investigative chronology, description of scene, summaries of interviews…, physical and ballistic evidence summary, forensic evidence examination, autopsy findings, and investigative summary."

We found that questions or topics missing from investigative summaries meant that they were not addressed during the interviews themselves. Our review, in the main, found that the investigative summaries adequately encapsulated Homicide's overall investigation in an impartial manner.

In one instance, however, the summary and overall investigation failed to identify some inconsistencies among witnesses.

- *Case 4.* Civilian witnesses had divergent accounts of whether the involved suspect spoke to PPB officers and, among those who indicated that he did speak to officers, precisely what the suspect said.

In that case, the IA review and After-Action Report cited or highlighted the accounts of civilians consistent with officers. Conflicting accounts went unmentioned.

Given the large number of witnesses in the case, Homicide should have, at the least, provided a memorandum indicating where witness accounts were consistent and where they differed—a common practice in other agencies and one which the Department of Justice has frequently required departments to implement as part of settlement agreements.[12] The PPB has not yet implemented the practice that investigative summaries methodically detail where witness accounts converge and diverge. To do so will make investigations more consistently complete and allow supervisors and all subsequent reviewers of case files to make their own informed judgments as to witness credibility.

Recommendation 2008.7
The PPB should require that Homicide's investigative summaries always and systematically detail both similarities and differences among witness accounts.

Recommendation 5.6: *The PPB should develop detailed checklists or Incident Summary Forms—one for officer-involved shootings and one for in-custody deaths—along the lines of those used by the Miami-Dade Police Department and the Los Angeles County Sheriff's Department, which require investigators to report key information regarding every officer-involved shooting and in-custody death case.*

The PPB does not currently utilize a single checklist that captures and reports all key information about an officer-involved shooting or in-custody death. The PPB indicates that it does "collect most of the data found in the two example forms (Miami-Dade and Los Angeles)," with the collected data "organized by detectives in single a binder," which "is indexed and page numbered for easy usage, "as part of the Use of Force Review Board

[12] The DOJ's Memorandum of Agreement with the Metropolitan Police Department calls for investigations to "identify and report in writing all inconsistencies in officer and witness interview statements gathered during the investigation" (DOJ-MPD Memorandum of Agreement, Paragraph 81(g)). The consent decree in Detroit calls for investigations to address, and resolve where feasible, inconsistencies in witness statements (*United States v. City of Detroit* Consent Decree, Paragraph 28(a)).

process." Some of the information captured by the forms cited in the 2003 report and recommendation "can be found in the Force Data Collection Report form," which is completed not exclusively for officer-involved shootings but for all use of force incidents. Further, "the Officer-Involved Use of Deadly Force/In-Custody Death Outline/Checklist, in Appendix B of SOP 37 also covers many of the areas found in the two models."

Without suggesting that the PPB fails to record relevant data, it is nonetheless the case that a single checklist in machine readable form is preferable to the extent that it gives investigators a standardized form for securing necessary information. PPB investigators appear to be capturing the necessary information, but the use of a form, especially when integrated into a computerized risk management database system, can assist the Bureau in identifying similarities or trends in use of force.

Recommendation 5.13: *Completed investigative files should (a) number each page sequentially; (b) contain a detailed index; and (c) include an Investigator Log identifying each investigator's day-to-day work on the case.*

At present, all completed investigative files are numbered sequentially and contain a comprehensive index. The PPB informed us that the detectives' routine daily activities are not logged, but "any activity that is pertinent to the investigation is usually documented." Because "detectives make and receive numerous phone calls and contacts a day, not only on the officer-involved case but also on their other homicides," the PPB has concluded that the maintenance of a log would be overly burdensome. The Bureau instead relies on the whole of the case file becoming the authority or activity log.

The 2003 PARC report offered one scenario in which a log that inventories the whole of a detective's activities would be especially useful:

> For example, if a PPB executive wants to know why a given witness was not interviewed until three weeks after a shooting, the executive can go to the Investigator's Log and ascertain what efforts the investigator took to try and obtain an interview immediately after the incident (2003, p. 125).

We continue to believe in the importance of the log. The investigator's log can serve as a management or supervisory tool to help ensure consistently high-quality investigations. It can provide details about what avenues the Homicide detectives did not explore, explored but abandoned, or overlooked, which may prove important to subsequent reviewers of the case file. Such a log can also serve what is, in a sense, a beneficial investigative function. For instance, if a detective has attempted to contact a witness on multiple occasions but the witness cannot be reached or is uncooperative, this might be a useful piece of information in assessing a witnesses' overall reliability or importance.

The investigator's log is a tool that many other agencies have embraced and find valuable, as it provides an unambiguous, ongoing account of what are often complicated, intensive investigations. The use of a log will build upon the substantial improvements in documentation and file organization that the Bureau has already accomplished and institutionalized. We continue to promote to the value of an investigator log, as noted in **Recommendation 5.13**.

INTEGRITY OF THE INVESTIGATION

WITNESSES AND INTERVIEWS

Recommendation 5.10: *PPB investigators should identify and conduct thorough, unbiased, and tape-recorded interviews of all witnesses – including emergency and medical professionals who performed examinations or rendered treatment – in deadly force or in-custody death incidents. In addition, the PPB should also carefully monitor the quality and fairness of interviews conducted by members of the East County Major Crimes Team assisting them in such investigations. To ensure compliance with these recommendations, the PPB should: (a) implement Recommendations 4.12 to 4.15 outlined in the previous chapter, (b) train investigators in approved advanced interviewing techniques and provide annual refresher training on the subject; and (c) adopt measures to*

hold accountable those investigators who fail to conduct thorough, impartial interviews. If a civilian refuses to submit to a taped interview, investigators should (a) not begin the interview until the witness has signed a form acknowledging that he or she has refused to be interviewed on tape, and (b) present the witness with a written copy of the investigator's summary of statement and allow the witness to review the investigator's summary for accuracy. The witness should be permitted to make any corrections or amendments to the statement he or she feels is necessary. A copy of both the original and corrected or amended interview summaries should be included in the investigative file.

Our examination found increasing quality and consistency in interviews of both officer and civilian witnesses. Many interviews were fair, professional, and exhaustive, with less use of problematic leading questions.

We were particularly impressed by those interviews in which officer motivations, decision-making, and tactical planning were thoroughly probed. In many, Homicide asked the shooter or other significantly involved officers if there was "anything that you would have done differently," which is certainly an appropriate and valuable question. In some instances, skillful investigators followed up the question by asking questions about why officers rejected or embraced certain tactics and made particular decisions rather than others. Inquiry into whether officers considered certain options or alternatives allows officers to explain their instantaneous decision-making in a more detailed and thorough manner than they might otherwise.[13]

Of note for the present report is that the PPB continues to follow PARC's recommendation to tape record all interviews. "Pre-interviews" of witnesses apparently no longer occur. The PPB has declined to follow recommendations involving the mandatory recording of scene walk-throughs. An investigator checklist, in Detective Division SOP 37, is to guide investigator questioning of witnesses. "Accountability" for investigators "is ensured

[13] Indeed, the most common response to a question by Homicide investigators along the lines "Could you have resolved this differently?" or "Was there anything that you would have done differently?" was simply "No," a response that investigators most often did not pursue further.

through the Use of Force Review Board process," with "the multiple, thorough reviews taking place…meant to fully address all deficiencies," according to the PPB.

Still, we found some instances in which key witnesses were not interviewed.

- *Case 5.* Investigators failed to interview three sergeants, including one who was one of the first supervisors to arrive at the scene. Given the extraordinary nature of the case, the observations and actions of all supervisors would have been no significant value.

- *Case 1.* A responding officer, security guard, and staff at a hotel were not interviewed. The perspective of each would have been helpful to understanding the strategic and tactical issues the officers faced.

- *Case 9.* A responding Sergeant who initiated negotiations with a man holding three children hostage was not interviewed.

- *Case 6.* Two responding officers were not interviewed, despite Homicide having taken a report from the officer at the scene.

In some cases, witness statements were not tape recorded.

- *Case 9.* A SERT lieutenant's interview with Homicide was not tape recorded.

- *Case 4.* The statements of several civilian witnesses to an officer-involved shooting were either not recorded or the tapes were not included in the case file.

Our review also noted some instances in which leading or incomplete questioning of witnesses reduced the value of the interviews and completeness of the investigation.

- *Case 5.* Investigators failed to ask both involved patrol and SERT officers to explain their reason for electing not to attempt to secure and to render medical aid to a wounded suspect, despite the fact that at least one officer said that it appeared that the suspect was "bleeding out."

- *Case 2.* Homicide detectives did not probe officers concerning their plan for securing the suspect and motivation for subsequent actions.

With one exception, the deficiencies discussed above were generally not identified or corrected during the subsequent administrative review. They underscore the importance of the PPB remaining committed to interviewing thoroughly all witnesses, tape recording and transcribing all witness interviews, and ensuring unbiased and precise questioning in all such interviews.

Recommendation 5.7: *In deadly force and in-custody death cases, PPB investigators should prepare detailed crime scene sketches of the entire crime scene (or scenes). Such sketches should identify physical evidence at the scene and provide all relevant measurements. In all cases, investigators should include the sketches in the investigative file.*

Recommendation 5.8: *PPB investigators should be required to ask all involved parties and all witnesses either to draw their own sketches of the scene (or annotate a sketch already prepared by the investigative team) during their taped interviews. In each case, the interviewing officers should ask the interviewees to use unique numbers or letters to show the location(s) of themselves and others at the scene. If, as is often the case, individuals at the scene moved from their original location, the interviewees should be asked to note the movement with unique identifiers as well (e.g., the positions taken by Officer A may be noted in chronological order as A-1, A-2, and A-3 in chronological order). In addition, the interviewers should contemporaneously note on tape when such markings are made (e.g.,"The witness is now noting his initial location at the scene as B-1.").*

A Detective Division special order (SOP #37) requires that investigators complete crime scene sketches and include them in the case file. Our review of shootings confirms that detectives are indeed doing so, and such sketches are generally of a high quality.[14]

The PPB reports that "during the normal course of the interview process…, witnesses do at times draw sketches when appropriate or asked to by the interviewer." The potential value of graphic representations of a scene by those who witnessed events as they unfolded is high, and it almost always outweighs the cost, in terms of time, of having less directly involved or potentially less reliable witnesses complete such sketches anyway. Two reviewed shootings illustrate why asking only selected witnesses to complete sketches can be problematic.

- *Case 12.* In one case, investigators asked three eyewitnesses to provide sketches. Nine others were not asked to provide them. The case file does not make clear how investigators decided who should complete sketches.

- *Case 4.* Investigators did not ask all eyewitnesses to a shooting to provide a scene sketch. Accordingly, from the transcripts or audio tapes of the witness interviews, it was difficult to deduce where the witness was standing or where he or she reported to see the others at the scene.

Ideally, investigators should commit to securing sketches, or annotations of crime scene sketches, from all witnesses, regardless of the extent to which they might conjecture that it will ultimately be useful. They should also create collapsed or compiled summary sketches, as appropriate or necessary, that graphically represent varying or divergent witness representations or accounts of the scene. To do as we have recommended may prove unpopular with prosecutors who will have to contend with possibly conflicting evidence. We nonetheless think it is unwise to invest the police with complete discretion

[14] For some sketches in the reviewed cases, more detailed, relational measurements could have been a helpful, added feature that would assist those reviewing the case file in developing as accurate of an impression of the scene and events as possible.

such that some eyewitnesses make sketches and others do not. We reaffirm **Recommendation 5.8**.

PRESERVATION OF THE SCENE AND COLLECTION OF EVIDENCE

Recommendations 5.1 through **5.5:**
These recommendations concern the preservation of the scene at officer-involved shootings and the appropriate preservation and collection of evidence. The PPB has been responsive to each of these recommendations, and none of the officer-involved shootings reviewed for this report suggested problems or issues with the securing of the scene or evidence collection. We praise the Bureau for addressing the 2003 report's concerns about crime scene investigation and procedure. We present the PPB's specific responses to each of those recommendations in the Appendix.

III. INTERNAL AFFAIRS INVESTIGATION AND REVIEW

Recommendation 5.9: *Consistent with Recommendation 4.1, PPB investigations should focus not only on whether officers' use of deadly or high-risk force was appropriate, but also on the officers' policy and tactical decisions that led to the incident. A principal goal of investigations should be to collect evidence sufficient for PPB managers and executives to assess whether the officers could have met legitimate law enforcement objectives in a manner less likely to have led to the use of deadly or other high-risk force.*

PARC's 2003 report described a system for the review of officer-involved shootings in which the Homicide investigation was the only investigation. As the PPB pointed out, the IAD conducted an administrative investigation only "as needed." **Recommendation 5.9** was situated within this context, and the intent of the recommendation was to expand the inquiry to strategic and tactical considerations and reasonable and available alternatives to the use of deadly force.

The PPB has made notable progress toward implementing **Recommendation 5.9**. The Bureau replaced that older model with a more systematic, forward-thinking model that involves review by Internal Affairs, the Training Division, the Unit Commander, and a Use of Force Review Board. Within this system, IA "always conducts a review of officer-involved shootings and in-custody deaths," as the PPB notes. That review has a different scope than that of Homicide. The primary function of the Homicide investigation of an officer-involved shooting is to determine, to the highest degree of confidence possible, precisely what happened before and at the shooting. Homicide is to collect facts about *what* happened so that the DA or grand jury can decide whether to prosecute the officer. The essential question is whether the officer had an objectively reasonable belief that he or she or others faced an imminent threat of death or serious physical injury.

In contrast, the primary functions of an IA investigation are to conduct a comprehensive inquiry into the tactics and decision-making of officers from the inception of the shooting incident to its conclusion. That analysis helps to decide whether the shooting was in policy and clarifies the training, policy, and risk management ramifications of the incident. IA is to consider, and investigate as necessary, *why* a shooting occurred in the first place, not just whether the shooting was "in" or "out" of policy.

PPB Policy (§335.00, "Use of Force Review Boards") states that "IAD should interview the involved member unless the Detective Division's investigation covered all appropriate issues relating to policy, training and tactics." IA says that it "almost always" conducts compelled interviews, in addition to the Homicide interview, with the shooter in officer-involved shooting cases, doing so to "get at specific policy matters."

We have ongoing concerns that IAD is relying too much on the Homicide investigation to get at the facts. The factual information needed by Homicide and IAD is not congruent. Although duplication of effort is undesirable, it is possible to conduct parallel IAD and Homicide investigations and to share results both ways, with the notable exception of testimony from the shooter or others which raises Fifth Amendment issues.

In the officer-involved shootings that we reviewed, there were disappointingly few cases in which the IA investigation and review added anything substantive to the review process. In four cases, for which reviews proceeded around the time of the implementation of the Bureau's improved and current administrative review procedure, IA conducted no interviews.

- *Case 5.* In a complicated case involving many officers, IAD does not appear to have conducted any independent investigation. IA did not interview any officers or witnesses and did not collect any additional evidence. Instead, it appears that IA simply analyzed the Homicide investigation and identified PPB policies and procedures implicated by the officers' actions.

  A Precinct Commander's exemplary After-Action Report in the case criticized IA for not conducting its own interviews.

- *Case 8.* The IA investigation consists merely of a cursory, written summary of Homicide's interviews and evidence. IA conducts no interviews.

- *Case 10.* The IA report in another case contained no interviews of the officer who used lethal force, another who fired a less lethal weapon, or any other witnesses.

- *Case 11.* The IA report summarizes officer and witness statements given to Homicide. IA conducted no interviews.

In other instances, IA conducted a limited number, or cursory, interviews.

- *Case 4.* The only additional investigative work performed by IAD was a seven-minute interview, occurring about 13 weeks after the shooting, of the officer who employed force. That interview failed to address numerous tactical issues, including the presence of endangered bystanders and the advisability of tactical

retreat. The memorandum outlining and discussing charges against the officer provided only a small sample of statements provided by numerous civilian witnesses; the summary does not mention those witnesses whose accounts appeared inconsistent with the involved officers' accounts.

- *Case 12.* IA conducted additional interviews of the involved officers but did not interview any of the numerous civilian witnesses. As the Homicide interviews did not clearly establish the distances from the suspect of each of the witnesses, such interviews would have been relevant in considering the officers' threat assessment.

- *Case 6.* IA re-interviewed only the officer who had fired rather than all involved, and other responding, officers.

Investigators in one case conducted a substandard interview that caused key facts to be overlooked.

- *Case 7.* An investigator in a negligent discharge case asks questions of the involved officer that introduce explanations or justifications for specific decisions or actions that the officer had not yet mentioned. Meanwhile, the officer fails to uncover that the involved officer wore tactical gloves that may have contributed to the negligent discharge. As the tactical gloves in the negligent discharge case are referenced in the case's After-Action Report, this information was uncovered subsequently. The case file contains no information as to when such information was uncovered, who discovered it, and whether any review as to why it as not discovered earlier occurred.

Based upon the files we reviewed, we are concerned that IAD, in the time period covered, had not yet fully grasped the new and expanded mission created by the PPB's adoption of the PARC recommendations.

Given that these are the very first shooting investigations conducted after the PARC recommendations were presented in August 2003, it is important to afford latitude to IAD as it learns and becomes accustomed to its new role. We hope and expect that more recent investigations will show marked improvement. Our interviews with the current leadership of IAD were encouraging in this regard.

The re-interviewing of involved officers and witnesses strengthens the quality of IA investigations. It allows the Department to be uniformly objective and thorough in considering the totality of officers' decision-making and situational awareness. It allows officers to explain fully the incident in a manner that they often cannot or do not in interviews with Homicide. It provides supervisors with a far richer investigatory record from which to make training, discipline, and other managerial decisions.

Accordingly, we urge the Bureau to ensure adherence to **Recommendation 2006.5**.

Recommendation 2006.5: *PPB Policy should require that Internal Affairs, as part of its administrative investigation of deadly force incidents, interview the involved officers, unless Homicide's investigation has covered all appropriate issues relating to policy, training, and tactics.*

During interviews with the officer who employed force, IA investigators should, in their questioning, elicit not simply a rote recounting of the story of what happened but, rather, inquire as to justifications and explanations for specific tactical decisions. Interviews with other key witnesses should be geared toward consideration of the whole of the incident, not just the decision to use force. We are not, however, advocating that IAD merely duplicate what Homicide has already investigated. Rather, we urge IAD to pursue avenues of inquiry relevant to IAD's charge which are not in Homicide's bailiwick.

Further, and for the same reason, we recommend here that the Bureau encourage IA investigators to re-interview any or all important civilian or officer witnesses such that its inquiry can be as complete and considered as possible.

Recommendation 2008.8

The PPB should require that Internal Affairs re-interview key civilian and officer witnesses to officer-involved shootings, unless Homicide's investigation has covered all appropriate issues relating to policy, training, and tactics.

IV. TRAINING BUREAU ANALYSIS

The Training Bureau currently conducts a review of all officer-involved shootings to consider whether officer actions were consistent with training and whether tactics employed during an incident suggest that other or additional training in particular areas may be necessary.

As noted in the previous discussions of supervision and field tactics, we found several Training Division reviews that were thorough, well-considered, and useful. They made several recommendations for future training that allowed the PPB to take substantive, real-world lessons learned and provide them directly to officers.

- *Case 7.* The review of an incident involving accidental discharge of a "lighted Glock," or a Glock outfitted with a tactical light, was thorough. It noted that the involved officer's attempt to switch hands with the gun and tap a switch on the gun that would activate the light may have contributed to the discharge. The review recommended continued in-service training emphasizing handgun manipulation under stressful situations and the creation of a formal training module on manipulation of lighted Glocks.

- *Case 8.* The Training review in another instance was concise and thorough. It praised involved officers for what they did well and identified multiple areas for improvement. Specifically, it noted inter-agency communication problems that the Bureau should address, reiterated the need for continuing firearms

training using realistic scenarios and simulations, and advocated for the PPB to develop a definitive position on whether officers should be instructed not to use the AR-15 as a tool for clearing residences or enclosed areas. Such discussions and recommendations were appropriate and valuable.

- *Case 9.* The review of the case involving a man holding hostages was critical of on-scene supervisors failing to activate SERT earlier. It made a number of constructive recommendations that focused on providing newly promoted sergeants with expanded critical incident training, ongoing training upon becoming sergeant, and a senior, mentor sergeant.

Yet other Training Division analyses left important tactical issues unaddressed.

- *Case 4.* The review failed to criticize involved officers for failure to communicate a pursuit in progress in a timely manner, the affirmative decision of involved officers not to employ cover at their disposal, and the extent to which officers failed consider tactical retreat.

- *Case 5.* The analysis was lacking in detail. The analysis did not expressly consider whether officers' actions were consistent with their training. Neither did the analysis articulate the Department's training with respect to the involved officers' actions or tactics. The analysis was unwilling to venture criticism of any officers with the exception of one sergeant. The After-Action Report in the case was definitively and notably superior in covering areas and issues that Training should have but did not.

As discussed previously, Training Division analyses tended to avoid considering the actions, or failures to act, of supervisors. Systematic, regularized appraisal of supervisors in all officer-involved shooting reviews should become the standard.

The Training Division analysis should do more than address whether an officer's actions were consistent with training. It should identify the sum of the reasonably available tactical choices available to the officer, discuss whether or to what extent PPB trains officers in those other choices, and consider the suitability of those choices, as well as additional training in those choices, in light of the conditions and situation that the officer-involved shooting presents.

Recommendation 2008.9
The Training Division should utilize a standardized format for its written report on its review of officer-involved shootings that require, in addition to review of what involved officers did during a given incident, (a) systematic appraisal of all supervisors involved at any point during the incident, and (b) standardized consideration of the availability and suitability of tactical options not used or considered for use by involved officers to evaluate potential need for additional, or different, training in such areas.

V. AFTER-ACTION REPORTS

Our review found the PPB's After-Action Reports increased in quality, substance and usefulness. After-Action Reports are generally completed by the Unit Commander of the officer who employed lethal force.

Recommendation 6.6: *The PPB should devise an accountability process to ensure that After-Action Reports comply with the content requirements of Section 1010.10 and engage in meaningful analysis.*

Many reports that we reviewed contained effective, thorough analysis.

- *Case 5.* The report was exhaustive, exploring key issues in great detail and making numerous, appropriate assessments and recommendations. The quality

of the analysis and discussion was superlative. It did not merely assess the use of deadly force but examined the series of events that led to the force. It identified shortcomings in officers' tactics and decision-making that other levels of administrative review did not consider. It considered not merely what happened but why it did.

- *Case 9.* The report capably incorporated recommendations and insights from the IA and Training reviews and carefully scrutinizes officer behavior.

- *Case 11.* The After-Action Report was cogent, succinct, and of high quality. It reiterated recommendations from the Training analysis and thoughtfully adds several others.

After-Action reports must also, as previously noted, rigorously and carefully consider not just the actions of involved officers but also of supervisors. Such routine inquiry will allow the PPB to improve further the quality of its critical incident management, supervisor training, and management.

VI. CONCLUSION

The quality and comprehensiveness of the internal, administrative reviews of officer-involved shootings has increased considerably since PARC's initial 2003 report. We commend the PPB and its efforts to raise the thoughtfulness of the analysis of such incidents and the scope of the inquiry. According to our interviews of PPB leaders, the PPB is now considering not just whether a use of force is justified per law and policy but also the tactics and decisions preceding the shooting.

The Bureau must yet ensure that administrative reviews are as thorough and complete as possible. Some changes that occurred in IAD after these cases may be addressing the issues we identified. The mandatory re-interviewing of involved officers and key witnesses

by Internal Affairs will do much to expand the investigatory record in a manner that assists PPB management in making the necessary administrative and training decisions. We laud the PPB's commitment to administrative reviews that do not merely rehash the facts established by the Homicide investigation. If and when we have the opportunity to review more recent investigations of officer-involved shootings, we hope and expect to find that the Bureau learning and improving as much as it can from every officer-involved shooting.

Recommendation 2008.1

The PPB should implement policy setting forth the selection, duties, and responsibilities of on-scene supervisors in all critical incidents, even when they do not rise to the level requiring a SERT rollout. The on-scene supervisor should notify unit or area commanders in the most expedient manner possible such that lieutenants and captains can respond to the scene without delay.

Recommendation 2008.2

There should be a single definition of "critical incident" for all purposes. It should include all circumstances described in §631.34. The definition should be expanded to include situations in which a member of the Bureau is injured, killed, uses deadly force, uses physical force resulting in serious physical injury, or is involved in possible criminal activity; or commits a homicide. It also should include situations involving barricaded persons and hostages; "situations that may induce widespread community fear"; "events that are likely to interrupt daily activity on a large scale" or "generate extraordinary community concern or media attention"; a "serious hate/bias crime" has occurred; or a "serious traffic crash" has occurred.

Recommendation 2008.3

PPB policy should dictate that when a Taser is used against a subject it shall be for one standard discharge cycle and the member using the Taser must then reassess the situation. Only the minimum number of cycles necessary to place the subject in custody shall be used. The Bureau should strongly advise officers against using more than three standard discharge cycles against any subject such that, if the third cycle does not make contact or is ineffective, the officer considers other options. The Bureau should automatically, systematically, and critically examine instances in which the Taser has been cycled for more than three standard cycles.

Recommendation 2008.4

The PPB should devise a more specific policy on beanbag shotguns and impact munitions consistent with the foregoing.

Recommendation 2008.5

The Bureau should create a policy relating to the use of the AR-15 that approves its use where a precise, high-powered firearm is necessary and discourages its use during dynamic entry and slow clears.

Recommendation 2008.6

The PPB should clarify the 21-foot rule, emphasizing that it does not per se justify any shooting when the suspect is less than 21 feet away and is not applicable if the officer already has his gun drawn and pointed.

Recommendation 2008.7

The PPB should require that Homicide's investigative summaries always and systematically detail both similarities and differences among witness accounts.

Recommendation 2008.8

The PPB should require that Internal Affairs re-interview key civilian and officer witnesses to officer-involved shootings, unless Homicide's investigation has covered all appropriate issues relating to policy, training, and tactics.

Recommendation 2008.9

The Training Division should utilize a standardized format for its written report on its review of officer-involved shootings that require, in addition to review of what involved officers did during a given incident, (a) systematic appraisal of all supervisors involved at any point during the incident, and (b) standardized consideration of the availability and suitability of tactical options not used or considered for use by involved officers to evaluate potential need for additional, or different, training in such areas.

Appendices

A

PPB Policy
Section 1010.20 Physical Force

1010.20 Physical Force
Revision # 5
Index: Title:
Refer: ORS 161.015 (7) Physical Injury, defined
ORS 161.205 – 161.265 Use of Physical Force
DIR 630.45 Emergency Medical Custody Transports
DIR 630.50 Emergency Medical Aid
DIR 910.00 Field Reporting Handbook Instructions
DIR 940.00 After Action Reports

POLICY (1010.20)

The Portland Police Bureau recognizes that duty may require members to use force. The Bureau requires that members be capable of using effective force when appropriate. It is the policy of the Bureau to accomplish its mission as effectively as possible with as little reliance on force as practical.

The Bureau places a high value on resolving confrontations, when practical, with less force than the maximum that may be allowed by law. The Bureau also places a high value on the use of de-escalation tools that minimize the need to use force.

The Bureau is dedicated to providing the training, resources and management that help members safely and effectively resolve confrontations through the application of de-escalation tools and lower levels of force.

It is the policy of the Bureau that members use only the force reasonably necessary under the totality of circumstances to perform their duties and resolve confrontations effectively and safely. The Bureau expects members to develop and display, over the course of their practice of law enforcement, the skills and abilities that allow them to regularly resolve confrontations without resorting to the higher levels of allowable force.

Such force may be used to accomplish the following official purposes:
a. Prevent or terminate the commission or attempted commission of an offense.
b. Lawfully take a person into custody, make an arrest, or prevent an escape.
c. Prevent a suicide or serious self-inflicted injury.
d. Defend the member or other person from the use of physical force.
e. Accomplish some official purpose or duty that is authorized by law or judicial decree.

When determining if a member **has used only the force reasonably necessary to perform their duties and resolve confrontations effectively and safely**, **the Bureau will consider the totality of circumstances faced by the member, including the following**:

a. The severity of the crime.
b. The impact of the person's behavior on the public.
c. The extent to which the person posed an immediate threat to the safety of officers, self or others.
d. The extent to which the person actively resisted efforts at control.
e. Whether the person attempted to avoid control by flight.
f. The time, tactics and resources available.
g. Any circumstance that affects the balance of interests between the government and the person.

The Bureau's levels of control model describes a range of effective tactical options and identifies an upper limit on the force that may potentially be used given a particular level of threat. However, authority to use force under this policy is determined by the totality of circumstances at a scene rather than any mechanical model.

PROCEDURE (1010.20)

Directive Specific Definitions

Force: Physical contact that is readily capable of causing physical injury, as well as the pointing of a firearm.

Physical injury: As defined in ORS 161.015 (7), the impairment of physical condition or substantial pain.

Precipitation of Use of Force Prohibited (1010.20)

Members should recognize that their approach to confrontations may influence whether force becomes necessary and the extent to which force must be used.

Members must not precipitate a use of force by placing themselves or others in jeopardy through actions that are inconsistent with the Police Bureau's defensive tactics and tactical training without a substantial justification for variation from recommended practice.

Vehicles (1010.20)

Due to the risks involved, members should not enter an occupied vehicle capable of being driven (i.e., engine running or keys in the ignition) except to address an immediate threat of death or serious physical injury to any person.

Post Use of Force Medical Attention (1010.20)

When a member is involved in the use of force in which physical injury has occurred or there is reason to believe there may be a physical injury, the member, if able, shall:

a. Continually monitor the subject if tactically appropriate or feasible. The member shall monitor the person for changes in skin or lip color, breathing and levels of consciousness. If any significant changes in any of these areas are observed, the member shall notify EMS immediately. See DIR 630.50 Emergency Medical Aid for further requirements.
b. Request EMS evaluate and treat those persons involved and injured prior to removal from the scene.
c. When pepper spray has been applied to a person, make every attempt to provide relief from the pepper spray exposure and move the person into an area of open air.
d. Contact the immediate supervisor and brief the supervisor on the incident.

e. Have the person transported to a medical facility for additional treatment if recommended by EMS. See DIR 630.45 Emergency Medical Custody Transports for important additional direction on transporting injured subjects.

f. When transporting a person from hospital treatment to a correctional facility, notify a corrections staff member of the extent of the person's injuries and medical treatment given and provide the corrections staff with the person's medical release forms from the medical facility.

If a person has been placed in maximum restraints or on the ground for control, members must do the following as soon as practical:

a. Release pressure/weight from the person's back or upper body.

b. Check and continue to monitor the person's breathing and pulse until EMS arrives.

c. Place the person in a seated position or position the person on their side to reduce the possibility of breathing problems by reducing the restriction to the person's diaphragm.

d. Provide EMS with an update on the person's condition if it appears to worsen.

For important additional guidance on transporting injured persons, see DIR 630.45 Emergency Medical Custody Transports.

Duty to Report and Notification and Reporting (1010.20)

Members have a duty to report any use of force that violates this Directive.

Members shall make a report when they use force to their supervisor or designee. Reports must be complete and accurate and describe the subject's behavior and the justification for the force used including a description of the totality of circumstances that existed.

A member who causes physical injury or who takes a person to the ground by applying force will complete a Force Data Collection Report (FDCR) in addition to any other reports required by Bureau policy. A member who applies a control hold that does not cause physical injury is not required to complete a FDCR for the control hold application. A member who applies a hold to gain control of a person, who follows commands and goes to the ground voluntarily without the application of additional force, is not required to complete a FDCR.

If the primary report and FDCR covering the specific incident are completed by one member, and another member used physical force in the incident, then each member who used physical force will complete a FDCR. The only exception to this is when the use of force was pointing a weapon at one or more persons (i.e., during a high risk stop). In that case only one FDCR need be completed.

The following circumstances do not require a FDCR:

a. Bureau approved training exercises (i.e., an in-service patrol tactics class).

b. A member unknowingly points a weapon at a person during a building search or other high risk situation (i.e., an undiscovered person was hiding behind an object at which a member pointed a weapon).

If a member's use of force results in a person being admitted to an overnight hospital stay for treatment, a supervisor will complete an after action report. The supervisor will forward the after action report, through their chain of command, to the appropriate Branch chief. The member's RU manager will forward a copy of the after action to the Internal Affairs Division and the Training Division.

If the member is injured and unable to submit a report, the report regarding the use of force will be completed by an on-duty supervisor.

Supervisors will be notified as soon as possible of the use of physical force which requires any person to receive medical attention.

Supervisors will ensure that members comply with the reporting requirements. Members shall follow DIR 940.00 After Action. Reports as it pertains to specific reporting requirements.

Canine (K-9) Bites (1010.20)

Canine handlers shall complete a FDCR for all bites that follow a member's intentional application of a police canine for the purpose of biting. The canine's handler will articulate the justification for the application of the canine and will state whether the bite was directed or not directed by the handler.

All police canine bites will be administratively reported by a supervisor, through channels, to the appropriate Branch chief in an after action report using the Bureau's standard format.

Handcuffing (1010.20)

Although handcuffing is not defined as physical force in this directive, Bureau policy requires that members document each handcuffing in a police report (i.e., Investigation, Custody or Special).

Supervisor Responsibilities (1010.20)

a. Supervisory Review of Reports

Supervisors shall review all reports of force to determine if the reports are complete and accurate and whether the force was justified under this policy. Supervisors shall address deficiencies in reports promptly.

b. Discipline Case Review Process

Supervisors are required to address all requirements of force policies when preparing proposed findings in misconduct investigations and must include all available information on the totality of circumstances.

Semi-annual Review of Use of Force (1010.20)

The Police Bureau will provide the training, resources and management necessary to help members comply with this directive.

Each operational unit will identify a unit-based group to review the unit's force practices and assist supervisors in conducting semi-annual reviews of each member's performance in confrontations. The reviews are a training function, and not a part of the discipline process. The goals of the review effort are to:

a. Ensure consistency and fairness.

b. Provide feedback to officers on force and confrontation decision making.

c. Identify training needs based on trends.

d. Create a positive learning environment.

B

PPB Responses to 2003 PARC Recommendations

This report considers the PPB's implementation of 36 recommendations, from chapters 5 and 7, in the 2003 PARC report concerning specific field tactics, policies, and procedures, as well as administrative review procedures. These recommendations are presented here with the written responses to them that the PPB provided to PARC during our review. In most cases, those responses are reprinted verbatim. In a few, we have edited to ensure confidentiality or to preserve clarity. The PPB has reviewed the Appendix to ensure that the responses, as printed here, are accurate and complete.

2003 PARC Recommendation	PPB Response
Recommendation 5.1: The PPB should adopt strict rules forbidding non-essential personnel from entering or remaining within the inner or outer perimeter of an officer-involved shooting or in custody death. By way of example, the PPB should provide that (a) involved parties and witnesses be removed from the crime scene immediately after the area has been secured; (b) personnel unrelated to the investigative unit, including union representatives, legal counsel, family members, and employee assistance-related officials may not enter the crime scene unless their presence is essential to the recovery or analysis of evidence and they have been requested or ordered to enter the crime scene by a properly authorized official within the investigative unit.	The concerns raised in this recommendation are addressed in General Order 640.10 Crime Scene Procedures, Detective Division S.O.P. #37 detailing the responsibilities of the on-duty homicide sergeant and including a comprehensive checklist for officer-involved shootings (Appendix A), as well as directive 1010.10 on Deadly Physical Force. These policies do not spell out that "union representatives, legal counsel, family members, and employee assistance-related officials may not enter the crime scene unless their presence is essential to the recovery or analysis of evidence…", as noted in 5.1(b). However, 640.10, section F makes clear that these parties are not permitted in the crime scene.

Recommendation 5.2: The PPB should introduce mechanisms to ensure that officials investigating officer-involved shooting and in-custody death cases promptly collect all relevant physical evidence at the scene. Such mechanisms should include, without limitation, (a) written guidelines, such as an investigators' manual, that specify investigators' evidence collection duties; (b) annual refresher training for investigators (and their supervisors) in forensic techniques and crime scene investigation; (c) on-scene investigation checklists and Incident Summary Forms to be included within each case file; and (d) methods for holding investigators accountable for their errors or omissions.	Both the (a) written guidelines and (c) on-scene checklist requirement are included in the ID Division "Homicide Investigation Checklist." This checklist covers the following actions and areas: *-Arrival at scene* *-Persons at scene* *-Photograph scene* *-Video tape* *-Process scene* *-Fingerprint scene* *-Victim* *-Survey scene* *-Scene area* *-Collect the evidence* *-Photograph defendant* *-Miscellaneous tasks* *-Autopsy processing* In regards to recommendation (b), the Captain of the Identification met with sergeants and representatives from our criminalists to develop annual in-service training for all of our criminalists. Lesson plans are currently being developed. The initial subject that will be covered included classes that would pertain to officer involved shootings: GSR / Presumptive Blood Testing, Blood Stain Pattern Analysis, Photography Review, Video Evidence Review, and Cyanoacrylate / Blood Print Processing. Recommendation (d) is covered by SOP 3.143, newly effective as of 12/06/07. This directive requires that a meeting take place between the relevant ID Sergeant and the Detective Sergeant within a week of the incident, and ensures that the Detective and Identification Divisions maintain a close working relationship. This relationship is critical as Criminalists work closely with the Detectives supervising each crime-scene, in a coordinated effort to ensure that procedures are followed strictly. Accountability is also ensured through the Use of Force Review Board process. The multiple, thorough reviews taking place in the review process are meant to fully address all investigative deficiencies.
Recommendation 5.3: Criminalists should be required to bring to the scene of officer-involved shooting and in-custody death cases all tools necessary to identify and collect physical evidence at the scene. Such equipment should include, among other items, (a) metal detectors to help locate weapons and ammunition, and (b) bullet trajectory analysis equipment sufficient to track and document the trajectory of ammunition regardless of caliber or make.	There are two homicide vehicles which contain the equipment used to collect evidence on scene. Each vehicle contains the following items, with **underlined items having been added as of 2003.** • Camera tripod • <u>Video camera tripod</u> • Video camera • <u>Handheld ALS</u> • Bag storage container • Small ladder or stepstool • Yellow bag of small placards 160 • Trace evidence vacuum and extra bags

	• Electrostatic dust lifter • Reciprocal saw • Toolbox containing: • Leather gloves, hand saw, rope, screwdrivers, wrench, hammer, utility knife, pry bar, shovel • Trajectory rod kit • Laser trajectory rod kit • Smaller size container for: • Swabs, pipettes, vionex, sticky scales, small evidence envelopes, syringe containers, test tubes, small evidence jars • Purple gloves • Umbrella • Halogen lights and electrical cords • Metal detectors • Reverse/backing up camera • 10x10 quick set up rain or shade tent • Bunny suits and booties • First aid kit • Fire extinguisher • Used syringe container • Metal blood spatter/wall scales in canvas bag • Large hipowered flashlight • Casting materials bucket • Storage bins • Knife boxes • Gun boxes • Rifle boxes • Small paperwork file folder for: • Property receipts, 8x10 adhesive sheets, special reports, home security pamphlets, note pad
Recommendation 5.4: The PPB should seek to collect muzzle GSR evidence in officer-involved shooting or in-custody death cases in which the location and angle of gunfire fire is relevant. Such evidence should be collected not only from skin, hair, and clothing, but from hard surfaces believed to be in close proximity to the weapon at the time of discharge. In addition, the PPB should collect	The PPB criminalists do have GSR kits that are procured from a variety of possible vendors, depending on cost and availability. Each vendor is connected with a specific laboratory, which is sent the kits for testing following their use by PPB. A list of current evidence collection vendors is included in the appendix. Additionally, research by PPB criminalists has noted that as of 2006, the Federal Bureau of Investigations (FBI) stopped using GSR tests. PPB criminalists are also aware of court cases being thrown out based of decreased confidence in the tests. One example is a 2006 case in Ankora, MD, details of which can be found from the following link: ;

primer GSR evidence in all officer-involved shooting or in custody death cases where there is some dispute about the identity of the person(s) who fired a gun or a claim by a civilian that an officer planted a gun at the scene. If the Oregon State Crime Laboratory remains unable to perform primer GSR analysis, then the PPB, like numerous agencies across the country, should seek to have the analysis performed at commercial or university laboratories.	Primer GSR tests are conducted when requested by investigators. Muzzle GSR tests focus on stippling and chemical/metals on the skin or clothing of the target. Criminalists will conduct test of clothing as requested by investigators, and photographs any defect (entry wound) in the skin using scale at a 90 degree angle to show size and shape of the stippling pattern.
Recommendation 5.5: The PPB should enforce the requirement of Section 1010.10 that investigators conduct a bullet trajectory analysis for each shot in an officer-involved shooting case where the bullet strikes one or more areas of the crime scene. The PPB should do so even where there is no dispute among witnesses regarding the underlying incident.	The PPB continues to test for bullet trajectory using three different methods for each bullet. On occasion, the PPB will ask an outside agency, like the Oregon State Crime Lab (OSP) or the East County Major Crimes Team (ECMCT) to conduct these tests. *The Identification Division uses three primary ways of examining and collecting bullet trajectory evidence; string, trajectory rods, and laser. The Identification Division has sent Criminalists to training in the study of bullet trajectory as recently as January 2008. They are still using the best methods for collecting this evidence as taught by a current national instructor.* It is the Detective's responsibility to ensure that trajectory reports are completed, as stated in 1010.10, and included in the Detective notebook.
Recommendation 5.6: The PPB should develop detailed checklists or Incident Summary Forms — one for officer-involved shootings and one for in-custody deaths — along the lines of those used by the Miami-Dade Police Department and the Los Angeles County Sheriff's Department, which require investigators to report key information regarding every officer-involved shooting and in-custody death case.	While the PPB does collect most of the data found in the two example forms (Miami-Dade and Los Angeles), the PPB does not currently organize it in a single form, as "back-up checklists for investigators" (PARC 2003, pg 99). The data collected in these cases are organized by detectives in a single binder as part of the Use of Force Review Board process. This binder is indexed and page numbered for easy usage. Some of the relevant information can be found in the Force Data collection Report form, which is in a similar format to the Miami-Dade example. However this form is not specifically geared towards shooting incidents, but covers all types of force instances. The Officer Involved use of Deadly Force/In-Custody Death Outline/Checklist in Appendix B of SOP 37 also covers many of the areas found in the two models, such as lighting conditions. As noted in the PARC first follow up report (2005), this check-list is "excellent," although it still lacks a focus on exploring opportunities for tactical retreat. The analysis conducted by the Training Division does cover retreat options when applicable. Reporting the "trajectory of all rounds fired" (PARC 2003, pg 99) is the responsibility of the Identification Division. Neither the Miami-Dade or the Los Angles examples appear to include this information. Ensuring that a trajectory analysis is completed is the responsibility of the Homicide Detail Sergeant and is noted in SOP 37 (see below in references section). It is also noted in 1010.10 (also below). In-custody death details are covered in section VII of the Officer Involved use of Deadly Force/In-Custody Death Outline/Checklist in Appendix B of SOP 37.

Recommendation 5.7: In deadly force and in-custody death cases, PPB investigators should prepare detailed crime scene sketches of the entire crime scene (or scenes). Such sketches should identify physical evidence at the scene and provide all relevant measurements. In all cases, investigators should include the sketches in the investigative file.	This recommendation covers crime scene sketches. Directive 1010.10 covering Detective Division Homicide Detail Responsibilities sections (a)(2) and (a)(3) state that the homicide detail will be responsible for scene sketches and diagrams. Additionally, Detective Division S.O.P. #37 section (c)(2) requires the preparation of a scene diagram.
Recommendation 5.8: PPB investigators should be required to ask all involved parties and all witnesses either to draw their own sketches of the scene (or annotate a sketch already prepared by the investigative team) during their taped interviews. In each case, the interviewing officers should ask the interviewees to use unique numbers or letters to show the location(s) of themselves and others at the scene. If, as is often the case, individuals at the scene moved from their original location, the interviewees should be asked to note the movement with unique identifiers as well (*e.g.*, the positions taken by Officer A may be noted in chronological order as A-1, A-2, and A-3 in chronological order). In addition, the interviewers should contemporaneously note on tape when such markings are made (*e.g.*,"The witness is now noting his initial location at the scene as B-1.").	The PPB requires the homicide detective to diagram the crime scene and include a legend (see 5.7 response for details). Witness interviews are conducted at the scene, and found in the officers reports. Additional taped interviews of both member and non-member participants and witnesses are conducted at a later date, transcripts of which appear in the Detectives notebook for the case. During the normal course of the interview process, which is guided by the interview checklist of SOP appendix B, witnesses do at times draw sketches when appropriate or asked to by the interviewer. They also utilize aerial photos and ground level photos to assist in their description of the events. These photos are marked in the fashion PARC recommends and entered as evidence.
Recommendation 5.9: Consistent with Recommendation 4.1, PPB investigations should focus not only on whether officers' use of deadly or high-risk force was appropriate, but also on the officers' policy and tactical decisions that led to the incident. A principal goal of investigations should be to collect evidence sufficient for PPB managers and executives to assess whether the officers could have met legitimate law enforcement objectives in a manner less likely to have led to the use of deadly or other high-risk force.	The PPB's initial response to recommendations 4.1 and 5.9 was the formulation of directive 335.00, the Performance Review and Use of Force Review Boards. In PARC's first follow-up report (2005), they note four problems with the draft form of 335.00. These areas were addressed in a revised 335.00/336.00 adopted as of Dec 21, 2007. The specific concerns were as follows: *1) That IAD, in coordination with training, will conduct an administrative investigation* ***as needed.*** In the updated version, this discretion is removed. IAD always conducts a review of officer involved shootings and in-custody deaths.

2) *There was a contradiction between whether the hospitalization of a suspect would trigger a review.*

This contradiction has been fixed. The section making such cases discretionary with the Chief has been removed. In the updated version, the section reads as follows:

The Use of Force Review Board's Scope (335.00)

a. To review the following use of force incidents:
   i. All officer involved shootings.
   ii. Serious injury caused by an officer that requires hospitalization and treatment.
   iii. All in-custody deaths.
   Etc. etc. etc.

3) *IAD was previously given 10 weeks in which to conduct its investigation, which is too long.*

In the updated version, IAD now has 6 weeks in which to conduct its investigation, following a 2 week review/coordination with the Training Division. The section reads as follows:

IAD Manager Responsibilities (335.00)

a. To review the following use of force incidents:
   i. Upon receipt of the completed Detective Division case notebook, IAD will have two weeks to review the case notebook and meet with representatives of the Training and Detective Divisions. The purpose of this meeting is to review the relevant issues of the event and to designate responsibilities for each RU's analysis.
   ii. IAD will then have six weeks to complete its investigation.
      1. IAD should interview the involved member unless the Detective Division's investigation covered all appropriate issues relating to policy, training and tactics.

Etc. etc.etc.

4) *The Homicide Detective investigation was too removed from the IAD investigation, and did not adequately cover the type of administrative and tactical issues that IAD and Training need to focus on.*

Detectives and investigators from both IAD and Training meet to coordinate the best way to address administrative and tactical issues. Directive 335.00 ensures that meetings between these three investigative groups occur on every Officer-Involved Shooting and In-Custody Death case, further enhancing each division's understanding of the other divisions.

<u>*Lieutenant, IAD:*</u>

Meeting within two weeks after receiving the case notebook has forged a connection between IAD, Training and Detectives, allowing Administrative and Tactical issues to be addressed prior to the IAD investigation review.

Recommendation 5.10: PPB investigators should identify and conduct thorough, unbiased, and tape-recorded interviews of all witnesses – including emergency and medical professionals who performed examinations or rendered treatment – in deadly force or in-custody death incidents. In addition, the PPB should also carefully monitor the quality and fairness of interviews conducted by members of the East County Major Crimes Team assisting them in such investigations. To ensure compliance with these recommendations, the PPB should: (a) implement Recommendations 4.12 to 4.15 outlined in the previous chapter, (b) train investigators in approved advanced interviewing techniques and provide annual refresher training on the subject; and (c) adopt measures to hold accountable those investigators who fail to conduct thorough, impartial interviews. If a civilian refuses to submit to a taped interview, investigators should (a) not begin the interview until the witness has signed a form acknowledging that he or she has refused to be interviewed on tape, and (b) present the witness with a written copy of the investigator's summary of statement and allow the witness to review the investigator's summary for accuracy. The witness should be permitted to make any corrections or amendments to the statement he or she feels is necessary. A copy of both the original and corrected or amended interview summaries should be included in the investigative file.	The PPB continuously tries to improve our working relationship with outside agencies. We have worked closely with ECMCT on not only PPB Use of Force and shootings, but on joint homicide investigations. The last joint training conducted was in the fall of 2007. Lt. Burke and Detective Austria conducted a power point presentation to the entire ECMCT on Officer Involved investigations and procedures. They have also sent out new ECMCT supervisors to shadow us on these types of cases. (a) – In PARCs first follow-up (2005), they noted the following concerning **4.12-4.15:** **4.12** – "Followed," that all witnesses should be interviewed on tape, with a "small concern that in practice some preliminary procedural matters are covered before the tape is turned on" which could inadvertently cause something important to be missed. **4.13 --** The PPB had declined to follow the recommendation that civilian witness interviews, when untapped, should be immediately typed up in a report and given to the civilian witness to review and confirm, or change. PARC found the PPB's response to and concerns to be "legitimate," with the caveat that on occasion transcripts did not match what the witnesses had said on tape. **4.14** – This recommendation suggests the PPB should video or audio record all scene walk-throughs with involved or witness officers. The PPB declines to follow the recommendation. **4.15** – "Followed," that untapped "pre-interviews" should be eliminated. (b) – PPB investigators now conduct interviews using the recommended advanced techniques by utilizing the "Officer Involved use of Deadly Force/In-Custody Death Outline/Checklist, Appendix B" of SOP 37, (c) – Accountability is ensured through the Use of Force Review Board process. The multiple, thorough reviews taking place in the review process are meant to fully address all deficiencies. All interviews are incorporated in the Detective notebooks for the Use of Force Review Board, and are analyzed within the overall review structure. Investigator responsibilities are specified in 335.00 and 336.00, and as investigators are required to adhere to the interview checklist, there is limited opportunity to go astray. Instances in which investigators conduct poor interviews would be identified during the Use of Force Review Board process. If a civilian refuses to submit to a taped interview: (a and b) – The PPB declines to follow these recommendations, as it permits and potentially encourages witnesses to change their original statements.
Recommendation 5.11: The investigative file for an officer-involved shooting or in-custody death should include all relevant evidence and information, including, without limitation, (a) color copies of pertinent crime scene photographs; (b) all videotapes taken of the scene; (d) all autopsy,	All Detective notebooks follow the same format. A model table of contents is included in the Appendix. The responsibilities for producing and maintaining the Detective notebooks for the Use of Force Board are codified in directives 335.00 and 1010.10. Concerning (a) and (b), all crime scene photographs and videos are taken and stored by the Identification Division. Copies of both are sent to Detectives upon request, and are included in the Detective

toxicology, and medical reports obtained by investigators (or a memorandum explaining why it was impossible to obtain such reports); (e) transcripts and audiotapes of all 911 calls and radio broadcasts (as well as relevant MDT transcripts); and (f) a memorandum presenting in summary fashion certain background information on the involved officers, including (i) date of hire and prior law enforcement experience; (ii) training history; (iii) assignment and promotion history; (iv) prior shootings or in custody death cases, if any; and (v) a record of any discipline, pending investigations, and awards or commendations.	notebook. Not all photos are included in the Detective notebooks, as many of the typically hundreds of photos taken of the scene are not useful. Taking video of the scene of an Officer-Involved Shooting is the subject of ID SOP 3.406, and is generally done in every Homicide and Officer-Involved Shooting. All medical documents noted in (c) are included in the Detective notebooks, as are audiotapes of 911 calls and radio broadcasts noted in (d), which are played at the Use of Force Review Board hearings as necessary. Transcripts of these calls are generally included in the Notebooks. Concerning (e), background information is covered in the interview process and is included in the Training and IA Divisions reviews, the files of which accompany the Detective notebooks when sent to the Use of Force Review Board and are stored by the Use of Force Review Board Coordinator as required in directive 335.00. The interview checklist in SOP 37 contains questions concerning the officer's background. This includes, in summary fashion, information on: -Training and experience -Prior law enforcement -Prior military experience -Other employment -Involvement in any other deadly force encounters -Current Assignment
Recommendation 5.12: Each investigative file should contain a detailed, comprehensive summary of the investigation. Although the summary should be impartial and take a neutral tone, it should also identify inconsistencies between statements and inconsistencies between statements and physical evidence.	Responsibility for conducting the investigation is held by the Detective Division, and required to be part of the case notebook by directive 335.00. In practice, the investigative report includes a summary with the following sections: -Incident Chronology -Investigative Chronology -Description of Scene -Summaries of interviews with involved members and witnesses. -Physical and Ballistic evidence summary. -Forensic evidence examination. -Autopsy findings. -Investigative Summary
Recommendation 5.13: Completed investigative files should (a) number each page sequentially; (b) contain a detailed index; and (c) include an Investigator Log identifying each investigator's day-to-day work on the case.	Recommendation (c) is addressed below by [Homicide Sergeant]. The PPB will in the future be numbered sequentially per section, with each section starting at page 1 and working up. This is to ensure that we can accommodate information and documents we receive, usually from outside sources such as the OSP Crime Lab, after the 30 day deadline to complete the folder. Late

	coming information can then be added to the back of the relevant section and not disrupt the entire binders page numbering. <u>*Detective, Homicide:*</u> *Our current policy holds the investigators to 30 days to complete the case book and have it ready for printing. Although in most cases we are able to get our reports done, other entities involved in the investigation are unable to complete their investigative role and get the reports back to us before the 30 day time limit. An example of this is the ME's Office and the OSP Crime Lab. Autopsy reports, and lab testing and results are usually not completed within the 30 days, especially if there is a toxicology screen, firearms trace, or DNA work needed. Because of this, their reports come in after the 30 days and after the case books have been numbered and printed. Some toxicology, firearms and DNA work, and reports could take up to 6 months to complete, and their are times that the toxicology screen and DNA testing* *IAD and IPR receive their case books as soon as they are done. When we get the completed reports from the ME's Office or the Crime Lab the books have already been numbered and the reports are inserted out of numbered sequence. We have to number the incoming reports, continuing from the last page of the original case file, and insert them in to marked section which takes the number sequence out of order. We also send these reports out as an addendum to those that already have their case books and have them change their table of contents to note the numbering sequence discrepancy.* *The detective's day to day activities are not logged, but any activity that is pertinent to the investigation is usually documented in the special reports that they prepare. For example, the detective will not document every unanswered phone call they make to a witness to schedule an interview. They will document in a report when the interview is scheduled and the content of the interview upon its completion. Detectives make and receive numerous phone calls and contacts a day, not only on the Officer involved case but also on their other homicides. They will document the pertinent events and information but they don't keep a running log of their day to day activities. As for monitoring their activities, the Sergeant in charge of the investigation meets with the detectives daily to discuss the investigation and the next course of action.*
Recommendation 5.14: All records, documents, and materials obtained or created in connection with an investigation of an officer-involved shooting or an in-custody death should be made, and should remain, a part of the official PPB file.	Detective notebook files are retained within the Records Division. Because of the special nature of Officer-Involved Shootings and In-Custody Deaths, these official files are stored separately in the Captain's office. All original crime scene photos and videos are kept within the Identification Division. The original Training and IAD reviews, which are part of the Use of Force Review Board process, are maintained by the Training and IA Divisions. As required by directive 335.00, the Use of Force Review Board Coordinator maintains copies of all of these documents and stores them as a single file, allowing for convenient review by Peer and Citizen Members of the Board and others.
Recommendation 5.15: The City of Portland	***Written response not received.***

should create an independent, professionally staffed, and adequately funded mechanism for civilian oversight of PPB investigations of administrative issues and analyses of tactical decisions arising out of officer-involved shootings and in-custody deaths. At a minimum the oversight mechanism would monitor: (a) Crime scene processes and procedures (this would involve rolling out to the scenes of officer-involved shootings and in-custody deaths); (b) Evidence collection and preservation; (c) Witness identification and interviewing; (d) Investigative file integrity and preservation; and (e) Presentation of evidence to the Review Level Committee.	
Recommendation 7.1: The PPB should ensure that operational personnel devise a sound plan before action is taken in response to critical incidents whenever it is feasible to do so.	This is considered a basic and critical tenant of officer training, and is stressed in the training document "Basic Police Academy Patrol Tactics" (page 12). This training document is utilized in both Advanced Academy and the yearly In-Service training. "Have a plan" is one of the 6 "Fundamental Concepts of Tactics." This training is also stressed as part of the two hour "Tactical Thinking and Planning" course (page 3). *2. **Have a plan.** Chances of succeeding and surviving are better if there is a tactical plan. Remember that in a survival situation we lose two thirds of our thinking ability. Think about approaches, positions of cover/concealment, how to direct cover officers in, officer down considerations, etc.* Additionally, it is the responsibility of the Training Division to review this subject in its analysis before the Use of Force Review Board. Following an overview of the incident, there is an analysis of each major action/decision. In appropriate instances, the first critical decision point is as follows: *Pre-Shooting: have a plan/have a leader.* <u>Sergeant, Training Division</u> *This is currently looked at in each Training Division shooting review. "Have a Plan" is one of the six Fundamental Concepts of Tactics which are taught in Patrol Tactics at both the Advanced Academy and the yearly In-Service.*

Recommendation 7.2: The PPB should ensure that the incidence of communications failures during police operations is minimized.	This is considered a basic and critical tenant of officer training, and is stressed in the training document "Basic Police Academy Patrol Tactics" (page 13). This training document is utilized in both Advanced Academy and the yearly In-Service training. "Communicate" is one of the 6 "Fundamental Concepts of Tactics." This training is also stressed as part of the two hour "Tactical Thinking and Planning" course. *5. **Communicate** before, during, and after tactical situations. communicate safe approaches, current observations and good critique after.* Additionally, it is the responsibility of the training division to review this subject, in its duties pertaining to the Use of Force Review Board. Following an overview of the incident, there is an analysis of each major action/decision. In appropriate instances, one of the action/decisions is as follows: *Containment: Be adaptable and communicate.* Communications issues are also identified by the Use of Force Review Board, which results in specific actions being taken. For example, case number 05107693 involving a communications failure during an Officer-Involved Shooting incident led to an external audit uncovering four major issues of concern. Responding to these concerns helped reinforce the following areas: *1. Critical incident training has been provided to command personnel.* *2. There are specific trained command personnel who respond as Incident Commanders* *3. Full time HNT Sergeant is assigned at Tactical Operations* *4. HNT / SERT train jointly* *5. Issues related to this incident have been debriefed and involved personnel have received training.* An additional case, 05100077, involving an officer in a foot pursuit who did not properly notify BOEC, was also reviewed by the Use of Force Review Board. In this case, the involved officers were debriefed regarding foot pursuit policy, and the Training Division took a fresh look at all communications-related training issues.
Recommendation 7.3: The PPB should ensure that supervisors become involved in the management of critical incidents at the earliest opportunity whenever such incidents arise.	Supervisors now conduct a three-day training course on Critical Incident Management as part of the broader eleven day Sergeant's Command School training. The most recent training course was given April 7-18, 2008. The Critical Incident Management focus is intended to solidify each supervisor's knowledge and understanding of their responsibilities at critical incidents. The course contains ample opportunity for supervisors to apply the concepts in scenarios and table top exercises.

	In addition, the PPB has an established Critical Incident Commander System in which one of four commanders always remain on call to respond and assume responsibility to tactical incidents requiring the action of SERT/HNT. This is codified in directive 720.00 Following incidents which do not require a SERT/HNT response, the actions and decisions of supervisors at the scene are debriefed and critiqued at the precinct level, and After Action Reports are produced when appropriate.
Recommendation 7.4: The PPB should ensure that, whenever feasible, supervisors are responsible for the determination and coordination of strategic and tactical responses to critical incidents.	Supervisors now receive a three-day training course on Critical Incident Management as part of the broader eleven day Sergeant's Command School training. The most recent training course was given April 7-18, 2008. The Critical Incident Management focus is intended to solidify each supervisor's knowledge and understanding of their responsibilities at critical incidents. The course contains ample opportunity for supervisors to apply the concepts in scenarios and table top exercises. Accountability is ensured through the Use of Force Review Board process. The multiple, thorough reviews taking place in the review process are meant to fully address all deficiencies.
Recommendation 7.5: The PPB should hold supervisors accountable for the performance of officers under their command during critical incidents.	*Same as Recommendation 7.4.*
Recommendation 7.6: The PPB should identify all high-risk building searches, high-risk warrant services, and calls regarding armed civilians as "critical incidents".	The PPB agrees with this recommendation to the extent that an automatic SERT callout is required on all high-risk building searches and high-risk warrant services. This is currently PPB policy and practice. The "Threat Assessment Formula" is used to determine whether an incident is designated as a Critical Incident. The PPB does not agree that all calls regarding armed civilians should be referred to SERT. Street officers are trained and capable of handling calls that do not qualify as a critical incident, as specified in procedure 631.34. <u>*Lieutenant, Tactical Operations Division:*</u> *"High risk" warrant service and "high risk" building searches already require the involvement of SERT/HNT and a critical incident commander. A call involving an armed civilian does not necessarily rise to the level of having SERT/HNT and an incident commander respond unless the civilian is barricaded or has fled into a contained area. Uniform handles calls involving armed civilians on a regular basis. (Some as victims, some as witnesses, some as suspects.) Many of these calls involve victims in need of immediate*

	assistance such as shots fired with victim down. SERT response usually takes a minimum of thirty to sixty minutes to get members on scene. To have SERT/HNT and an incident commander respond to all calls involving an armed civilian would not be practical. If an armed suspect is contained in an area by uniform officers, policy already requires the response of SERT/HNT. *The 'Manual of Policy and Procedure' defines critical incidents only in 631.34 Critical Incident Notifications, which identifies those incidents requiring PIO, Chief of Police, Police Commissioner, and Mayor to be notified. Not all 'high risk' building searches or search warrants should require the notification of the Mayor. Policy already requires the notification of the Operations Branch Chief for those incidents requiring SERT/HNT.*
Recommendation 7.7: The PPB should emphasize the relevance of supervisors' critical incident training to routine police operations.	*Same as Recommendation 7.7.*
Recommendation 7.8: The PPB should ensure that field performance consistently reflects the Bureau's tactical training in all areas, and particularly in relation to identified problems relating to high risk vehicle stops, the use of cover, cross fires and bystander endangerment.	These areas are considered basic and critical tenants of officer training. High risk vehicle stops are covered in specific training courses regarding this area. The use of cover is stressed in training for basic Police Academy patrol tactics. The issue of cross fires is addressed in the training for Perimeters and Block Searchers. Cross fires and bystander endangerment are addressed in training for Firearms Instruction, with the fourth Cardinal Firearm Safety Rule being: ***Be sure of your target and backstop***. *Know what your target is, what is in line with it, and what is behind it. Never shoot at anything you have not positively identified. Be aware of your surroundings, whether on the range or in a deadly force situation. Do not assume anything. Make sure if circumstances permit that the backstop will stop the type of ammunition you are shooting.* In addition, the use of cover and concealment, crossfire awareness and bystander endangerment are discussed during other training sessions, when related to the prime focus area. For instance, these areas are discussed during training for "High Risk Traffic Stops" (pages 3, 8). It is the responsibility of the Training division to review these areas as they come up in practice, and to adjust training curriculum accordingly. Accountability is ensured through the Use of Force Review Board process. The multiple, thorough reviews taking place in the review process are meant to fully address all deficiencies. In addition, accountability is codified in directive *315.30–Unsatisfactory Performance*, which is below in its entirety.

	Sergeant, Training Division *This is currently looked at in each Training Division shooting review. These areas are part of the PPB Training Division Tactical Guideline Elements which are taught in the Advanced Academy and the yearly In-Service.*
Recommendation 7.9: The PPB should ensure that supervisors consistently manage vehicle pursuits to a high standard.	The supervisory role of managing vehicle pursuits is stressed in the Sgt.'s Academy training power point document entitled "Pursuit Management," along with other training documents listed below. The supervisor's responsibilities are also codified in 630.05. In addition, all pursuits require an After Action report, which is received and reviewed by the relevant A/C.
Recommendation 7.10: The PPB should ensure that its officers maintain sufficient distance when pursuing armed suspects in a vehicle.	The PPB agrees that officers should maintain sufficient distance when pursuing armed suspects in a vehicle. As recently as November 7, 2007, directive 630.05 concerning Vehicle Pursuits was updated to fully reflect bureau policy. This policy, along with the training document "Pursuit Management," stress that officers must take into account the risk vs. reward balance in deciding whether to, for instance, perform a maneuver to end a vehicle chase. *Officer, Training Division:* *In response to PARC's recommendation 7.10 on officers maintaining sufficient distance when pursuing armed suspects in a vehicle. Directive 630.05 vehicle pursuits states "It should be the goal of members to employ pursuit intervention strategies to prevent or to use the strategies to end a pursuit as quickly as possible". We teach our officers to continually weigh the benefits of the pursuit verse the risk to the community.* ***Safe following distance is stressed in all training we do****. However, if we teach our officers to only pursue the vehicle at a safe distance in every circumstance we take away the option to end the pursuit on our terms when we feel it is safe. We also open the community up to undo risk by just pursuing at a distance with no option to end the pursuit. The Training Division teaches officers to have options built into every pursuit depending on the circumstances and conditions.*
Recommendation 7.11: The PPB should adopt and enforce a policy mandating the use of sound foot pursuit tactics by its officers.	***Written response not received.***
Recommendation 7.12: The PPB should ensure that officers make appropriate use of cover when confronting threats.	This is considered a basic and critical tenant of officer training, and is stressed in the training document "Basic Police Academy Patrol Tactics" (pages 14-16). This training document is utilized in both Advanced Academy and the yearly In-Service training. "Cover and Concealment" is one of the 5 "Tactical Advantages."

	In addition, PPB Firearms Instructors teach officers in the Advanced Academy and at yearly In-Service training to always seek and use available cover when conditions allow. It is the responsibility of the Training Division to review this area as it comes up in practice, and to adjust training curriculum accordingly. <u>Sergeant, Training Division:</u> *This is currently looked at in each Training Division shooting review. "Cover and Concealment" is one of the 5 Tactical Advantages which are taught in Patrol Tactics at both the Advanced Academy and the yearly In-Service.*
Recommendation 7.13: The PPB should ensure that the incidence of cross fires is minimized.	This is considered a basic and critical tenant of officer training, and is stressed in the training document "Firearms Instruction lesson plan outline and presentation" (page 2). This training document is utilized in both Advanced Academy and the yearly In-Service training. "Be sure of your target and backstop" is one of the four "Cardinal Rules of Firearms." ***Be sure of your target and backstop***. *Know what your target is, what is in line with it, and what is behind it. Never shoot at anything you have not positively identified. Be aware of your surroundings, whether on the range or in a deadly force situation. Do not assume anything. Make sure if circumstances permit that the backstop will stop the type of ammunition you are shooting.* In addition, crossfire is discussed during other training sessions, when related to the prime focus area. For instance, these areas are discussed during training for "High Risk Traffic Stops" (pages 3, 8). It is the responsibility of the training division to review this area as it comes up in practice, and to adjust training regiments accordingly. <u>Sergeant, Training Division:</u> *This is currently looked at in each Training Division shooting review. "Be aware of your target, backstop, and what's beyond" is one of the Four Cardinal Rules of Firearms that are taught in both the Advanced Academy and the yearly In-Service.*
Recommendation 7.14: The PPB should ensure that the incidence of endangerments to bystanders is minimized.	This is considered a basic and critical tenant of officer training, and is stressed in the Firearms Instruction training document "Firearms Instruction lesson plan outline and presentation" (page 2). This training document is utilized in both Advanced Academy and the yearly In-Service training. "Be sure of your target and backstop" is one of the four "Cardinal Rules of Firearms." ***Be sure of your target and backstop***.

	Know what your target is, what is in line with it, and what is behind it. Never shoot at anything you have not positively identified. Be aware of your surroundings, whether on the range or in a deadly force situation. Do not assume anything. Make sure if circumstances permit that the backstop will stop the type of ammunition you are shooting. It is the responsibility of the training division to review this area as it comes up in practice, and to adjust training regiments accordingly. <u>Sergeant, Training Division</u> *This is currently looked at in each Training Division shooting review. "Be aware of your target, backstop, and what's beyond" is one of the Four Cardinal Rules of Firearms that are taught in both the Advanced Academy and the yearly In-Service.*
Recommendation 7.15: The PPB should revise its existing policy on the use of firearms against moving vehicles. The revised policy should include a preface explaining that shooting at moving vehicles is dangerous and generally ineffective, and should embody the following guidelines: • Officers shall not fire at moving vehicles except to counter an imminent danger of death or serious bodily harm to the officer or another person. • Officers shall only fire at a moving vehicle when no other means of avoiding or eliminating the danger it presents are available at that time. • Officers shall not place themselves, or remain, in the path of a moving vehicle. • Officers shall take account of risks to vehicular and pedestrian traffic, and to any other bystanders, before deciding whether to fire at a moving vehicle. • Officers shall take account of risks to vehicle occupants, who may not be involved (or may be involved to a lesser extent) in the actions necessitating the use of deadly force before deciding whether to fire at a moving vehicle.	***Written response not received.***

Recommendation 7.16: The PPB should take steps to minimize the risk of accidental discharges.	This is considered a basic and critical tenant of officer training, and is stressed in the training document "Firearms Instruction lesson plan outline and presentation" (page 2). This training document is utilized in both Advanced Academy and the yearly In-Service training. "Never put your finger on the trigger until you are on target and ready to fire" is one of the four "Cardinal Rules of Firearms." ***Never put your finger on the trigger until you are on target and ready to fire*** *This rule is violated especially by those who are uneducated in the handling of firearms. TV, Theaters, pictures, etc, seem fascinated with having their finger on the trigger. It is unprofessional, dangerous, and perhaps, most damaging to your reputation as a person who carries or handles firearms. If you fire a round it better be on purpose and in the direction you intended.* Officers are held accountable by ensuring that policy procedures are followed. These include a section of directive 1010.10–Deadly Physical Force which deals specifically with Negligent Dishcharges. IAD and the Training Division have been reviewing these in much the same way as an officer involved shooting or in-custody death. There have been five cases in the past three years in which a Performance Review Board finding has determined that a negligent discharge has occurred, and in which the finding has been sustained. The list of case numbers can be found below. <u>Sergeant, Training Division:</u> *The Detective Division investigates these cases. The Training Division emphasizes techniques to avoid this in Patrol Tactics and Firearms training. "Keep your finger off the trigger and out of the trigger guard until you are on target and intend to fire" is one of the Four Cardinal Rules of Firearms that are taught in both the Advanced Academy and the yearly In-Service.*
Recommendation 7.17: The PPB's Training Division should reconsider its current training in maneuvers that involve weak-handed shooting.	The PPB agrees that a high-level of training is critical for ensuring proper use of weak-handed shooting, which includes the judgment to rely on the strong hand whenever possible. Officers are taught to use weak or support hand shooting in two circumstances: 1) in some tactical situations using the support hand gives the officer a tactical advantage. For example, the use of available cover coupled with support hand shooting may allow an officer to protect more of their body from a lethal threat. 2) Officers are taught to use support hand shooting if their strong hand becomes disabled. Again, officers are taught that they should always rely on strong hand shooting whenever possible.
Recommendation 7.18: The PPB should abandon use of term "lethal cover" in relation to less lethal weaponry training and deployment.	The PPB Manual of Policy and Procedure has replaced "lethal cover" with "immediate cover" in regards to the appropriate Taser usage. Immediate Cover is defined as follows:

	A member who stands ready to deploy additional control if needed (i.e., the Taser is ineffective or it fails to function properly).
Recommendation 7.19: The PPB should monitor and evaluate the effectiveness of all its less lethal hardware, and should tailor the availability and deployment of that hardware to ensure officers' access to effective and appropriate force options.	The PPB carefully and closely monitors and evaluates the Taser program and other less-lethal hardware usage. Responsibility for this is codified in the Manual of Policy and Procedure in sections 1050.00 (Less Lethal Weapons and Munitions) and 1051.00 (Taser, Less Lethal Weapon System). All Taser usage is recorded in a Use of Force Report, and all usage involving six cycles or more requires an After Action Report. Currently, all officers are certified and equipped with Tasers, which ensures that all officers have access to effective and appropriate force options.
Recommendation 7.20: The PPB should provide all operational personnel with a radio earpiece.	The PPB agrees that ear pieces are a valuable addition to the standard equipment list. Standard-fitting ear pieces have been distributed to officers in previous years. Additionally, officers are given the opportunity to purchase custom-fitted ear pieces using a discretionary equipment allowance. Many officers choose to use the fund for this purpose.
Recommendation 7.21: The PPB should establish a helicopter unit.	***Written response not received.***
Recommendation 7.22: The PPB should ensure that CIT officers consistently exercise their specialist skills when dealing with CIT-related incidents. **Recommendation 7.23:** The PPB should examine its current CIT deployment practices in order to identify means of maximizing the rate at which appropriately skilled officers attend CIT-related incidents.	The PPB has, in recent years, considerably stepped up its efforts to provide all PPB officers with the most advanced CIT training possible. This effort was significantly furthered by the hiring in May of 2007 of Liesbeth Gerritsen, PhD, a CIT expert. The CIT training curriculum has been completely revamped, and the full 40 hour training course is given to all PPB officers, both new recruits and those already on the force. As of July 14 2008, 495 PPB operations branch employees had received this training, with the remaining Operations branch employees to be trained by February 2009. The responsibilities of the CIT coordinator and CIT operatives are contained in directives 820.20 Mental Health Crises Response, and 850.25 Police Response to Mental Health Facilities, and are as follows: In addition, we have solicited the opinion of Jay Auslander from "Cascadia Project Respond," who is in a position to verify PPB officer utilization of CIT training. "Cascadia Project Respond" is a non-profit organization in Portland which offers mental health and addictions treatment services. PPB officers, in the normal course of their duties, often call on members of this organization to follow up with citizens who could possibly benefit from these services. Jay Auslander stated the following, on July 10, 2008: *Project Respond has provided crisis response and outreach services throughout Multnomah County for the past 15 years. Much of this work has been done in collaboration with PPB, and it is only with the active partnership of law enforcement that Project Respond has been able to provide a safety net for some of our most vulnerable citizens.* *Police/911 often are the first to hear about a mental health crisis, and we have made collaboration with Portland Police a priority. Police are one of our largest sources for new referrals of clients who have*

	not yet been in the mental health system. During the fiscal years 2005-2006 and 2006-2007, Portland Police referred 509 and 519 unduplicated clients, respectively. During the fiscal year 2007-2008, Portland Police referred 646 unduplicated clients, a noteworthy increase over the previous years. *The clinicians of Project Respond have long relied upon officers in the community, and interactions with PPB Officers consistently reveal an exceptional level of professionalism and commitment to the protection and service of everyone involved. PPB officers frequently display a working knowledge of issues relating to mental illness and are able to skillfully and therapeutically attend to the needs of those impacted.*
Recommendation 7.24: The PPB should ensure that officers consistently follow the Bureau's training and policy in relation to sudden death syndrome and associated prisoner restraint issues.	All relevant cases regarding these issues are reviewed by the appropriate members of the Training Division, who update and tailor officer training accordingly. At the present time, the term "sudden death syndrome" has been replaced by the term "excited delirium," which is a major component of officer training. Recent training exercises include the production of a roll-call video entitled "Hobble Review/Excited Delirium," as well as a 2006 roll-call video which includes section "Multiple Taser Use & Excited Delirium." In addition, a PPB Training Division "Tips and Techniques" refresher bulletin on response to "excited delirium" incidents is scheduled for distribution to all divisions in August 2008. Cases involving excited delirium are reviewed under a number of different circumstances: 1) When tasers or impact munitions are used to subdue a suspect with excited delirium, After-Action Reports are required. 2) When hospitalization is required of a suspect with excited delirium, After-Action Reports are required. 3) When a fatality occurs of a suspect with excited delirium, a Force Review Board review is required. Additionally, directive 630.45 Emergency Medical Custody Transports requires that officers remain aware of the issue of excited delirium when considering the transport of suspects. **PROCEDURE (630.45)** **Transportation of Subjects** Members will not transport subjects who appear to be seriously injured, seriously ill, or unconscious unless an on-scene evaluation by EMS determines the subject is cleared for officer transport. This includes, but is not limited to any subject who: **a. Appears to be suffering from excited delirium. Symptoms may appear as severe agitation, over stimulated or wired appearance, paranoia, disorientation, extreme restlessness, involuntary twitching of small muscles and hallucinations**. PPB training practices in regards to these issues are described below: <u>Lieutenant, Training Division</u> *The term "excited delirium" is now being used in replace of sudden death syndrome and positional asphyxia. Medical examiners are pushing for the term excited delirium to be accepted as a cause of death,*

	but the AMA has not yet agreed. The latest studies indicate that positional asphyxia does not exist. During the CIT training we go over this information. We recommend that we get medical rolling on the call as soon as we even think it might be excited delirium. That by the time law enforcement gets involved, the chances for the persons survival are slim. This is because the person is already so for into the delirium, even immediate medical intervention has a low chance of helping. Our goal is to get the person under physical control as quickly as possible. That means waiting for as many people as you can to show up before trying to physically engage with the person, have medical on scene and ready to take custody of the person right away and try to start medical intervention. The use of tasers is strongly encouraged, as it is a way to subdue the person and get them restrained in the quickest and safest way.

Responses of the Portland Police Commissioner and Chief of Police

CITY OF

PORTLAND, OREGON

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February 3, 2009

City of Portland
Auditor's Office
1221SW 4th Avenue
Portland, Oregon 97204

Dear Auditor Blackmer:

I am pleased with the work of the Portland Police Bureau to implement the comprehensive recommendations of the Police Assessment Resource Center (PARC) in its three reports since 2003.

The Portland Police Bureau, under the leadership of both Chief Foxworth and Chief Sizer, have worked to implement the 89 recommendations contained in the initial report, and the subsequent recommendations contained in the two prior follow-up reports. In this, the third follow-up report, I am very pleased to note the real and meaningful progress the Bureau has made to work "diligently and in good faith to improve" the Portland Police Bureau. The Bureau is well on its way to implementing all of the recommendations, and in the process has become a more self-reflective entity able to improve its service while increasing accountability and transparency.

I would like to thank your office for taking the lead on overseeing the completion of these reports. I would also like to thank PARC for the detailed and objective report regarding the Portland Police Bureau implementation of recommendations.

I look forward to continuing to work with PARC, the Portland Police Bureau and your office on the continuing implementation of the recommendations.

Sincerely,

Dan Saltzman
Police Commissioner

CITY OF PORTLAND, OREGON

Bureau of Police
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Integrity • Compassion • Accountability • Respect • Excellence • Service

MEMORANDUM

February 4, 2009

TO: Mr. Gary Blackmer, Auditor
City of Portland

SUBJECT: Portland Police Bureau Response to Police Assessment Research Center (PARC) Report

It is truly my privilege to lead the many hard working and dedicated police professionals who consistently provide quality service to this community under the difficult and often dangerous situations identified in this latest PARC report. I hope the citizens of Portland will join me in recognizing the significant efforts made by the members of the Police Bureau to learn, grow and self correct when necessary.

I want to thank PARC for its work over the years and for recognizing the progress made by the Bureau. I remain committed to continual improvement and working with our new police commissioner, members of the Bureau, the community and the Auditor's office to find new ways to ensure transparency and accountability and improve the service we provide.

This report clearly shows that the Portland Police Bureau is an increasingly excellent organization with the capacity to identify and implement new and promising policies and practices. Issues involving the use of force, and particularly deadly force, are among the most challenging to discuss and manage both inside and outside of the organization. As PARC notes, no matter how good a police department's policy, training and supervision may be, the unpredictability of circumstances requires that officers take measured risks and exercise split second decisions.

It is against this backdrop that I commit to reviewing how the Bureau can best implement the very few new recommendations made in this report. Some of the recommendations the Bureau has already implemented on its own. Others I will assign for review and follow up. I look forward to working with your office to move forward with the next step in this process, and to future reports that demonstrate how well the Bureau identifies and addresses issues raised by future officer involved shootings or in custody deaths.

Rosanne M Sizer

ROSANNE M. SIZER
Chief of Police