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

Police Assessment Resource Center
August 2003

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About PARC

The **Police Assessment Resource Center (PARC)** is a non-profit organization that supports and assists those responsible for the oversight of police departments -- monitors, law enforcement executives, civic officials, and government agencies -- to help them advance effective, respectful, and publicly accountable policing. Based in Los Angeles but working nationally, the Center serves as an honest broker of information accessible to anyone interested in police oversight and reform. The center publishes the *Best Practices Review,* a monthly e-mail newsletter, as well as short position papers and more detailed reports about individual law enforcement agencies. PARC sponsors fora on police accountability issues and emerging trends in the field, maintains and makes public a library of resources, and provides information to the media regarding policing issues in the news. Under the direction of Merrick J. Bobb, the nation's first police monitor, and guided by a diverse and experienced board of trustees, PARC also assists city officials, police departments, and monitors to implement reforms that are appropriate to the particular challenges facing police in a given jurisdiction.

A copy of this report, including its Appendix, is available online at www.parc.info.

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M E M O R A N D U M

To: Mayor Vera Katz
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Commissioner Erik Sten

From: Gary Blackmer, City Auditor

Date: August 26, 2003

Subject: 2003 Review of Officer-Involved Shootings

The Portland City Council authorized the City Auditor to hire an expert to conduct annual reviews of incidents of officer-involved shootings and deaths in police custody. Council instructed that these reviews emphasize policy-level recommendations with the goal of identifying any strategies for reducing the possibility of future incidents. My office's Independent Police Review Division (IPR) issued a request for proposals and selected the Police Assessment Resource Center (PARC) to conduct the first review.

Their attached report is an extraordinary document. It is a first-ever detailed, expert analysis of every aspect of the Portland Police Bureau's policies and practices related to these incidents. This report contains constructive solutions based upon the experts' decades of knowledge and experience, as well as the most current national research.

This report identifies many areas needing significant attention. You will also find an attached response from the Police Chief, with a commitment to follow through on the recommendations. I think this report will greatly enhance the mission of the Bureau's Community Police Organizational Review Team. If they seek additional information regarding this report they can contact Richard Rosenthal, the IPR Director.

This document is extraordinary in another way. While other cities have undergone investigations of their operations only after falling under the scrutiny of the U.S. Department of Justice or as the result of civil litigation, Portland sought out expert consultants to proactively assess its policies and practices. This review represents accountability to our community that, to my knowledge, no other city has been willing to undergo.

The IPR will monitor the Bureau's efforts in this area during the coming years. I also urge the City Council and our community to make a commitment to recognize and support the Bureau's progress toward these proposed solutions. 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

The Independent Police Review Division of the City Auditor's office retained the Police Assessment Resource Center (PARC) to conduct a review of the 32 officer-involved shootings and two in-custody deaths that occurred in the city of Portland between January 1, 1997 and June 30, 2000. Thirty of the shootings and the two in-custody deaths involved the Portland Police Bureau (PPB); two shootings involved other agencies acting inside the city of Portland. The purpose of the review was to identify issues relating to policy and quality of investigations that the PPB needs to address.

PARC comprehensively reviewed the PPB's files of the 34 incidents — involving some of the Bureau's most significant cases during the three-and-one-half-year period under review — and its policies and procedures regarding officer-involved shootings and in-custody deaths. PARC's conclusions concerning the PPB's investigatory and internal review processes included:

- The internal review mechanisms from 1997 to mid-2000 did not demonstrate a consistent commitment to meaningful review and did not generally result in lessons being learned from these incidents.

- The Bureau did not conduct a documented internal review, at either the unit or the executive level, of 31 percent of the 32 PPB incidents; the undocumented executive review of an additional 13 percent of the incidents did not conform to PPB policy.

- The investigatory model used by the PPB focused on whether a crime had been committed, and underemphasized the policy and tactical issues that are generally more consequential in these types of incidents.

- The PPB developed some exemplary policies relating to officer-involved shootings —specifically an interview protocol and peer support process —

but, overall, its policies and practices, including those relating to the promptness of obtaining statements from involved officers, and the taping and "pre-interviewing" of all witnesses, need improvement.

- Notwithstanding much good work, the PPB's investigators did not always conduct thorough and impartial investigations, and generally did not present the evidence obtained in those investigations in a clear, organized, and complete manner.

With respect to the incidents themselves, PARC concluded:

- Some of the 32 incidents demonstrated exemplary tactics and leadership; many demonstrated flaws in supervision, incident management, and field tactics that unnecessarily exposed officers to harm and increased the likelihood that they would need to use deadly force to defend themselves.

- The files on the 32 PPB incidents we reviewed gave no indications of the gratuitous use of firearms or other weapons, or of racial or ethnic bias.

As a result of these and other findings, PARC made 89 recommendations. Wherever we identified room for improvement we have recommended remedies. In some cases, where national best practices are clearly defined, our recommendations are specific. Where we see a range of potential solutions, we identify steps taken by various jurisdictions so that the PPB can consider which model might offer a "best fit" for Portland. In addition, we identified issues that that the Bureau can remedy by the more consistent application of existing capabilities and policies.

Notably, we made the following recommendations concerning officer-involved shooting and in-custody death incidents: change the model the PPB uses for investigating such incidents; take prompt statements from officers involved in such incidents; tape all witness interviews; end untaped "pre-interviews" of all witnesses,

including involved officers; include all records obtained in an investigation in official PPB files; establish auditor-type civilian oversight of administrative investigations of those cases; involve a professional, non-PPB civilian in the Bureau's internal review of these incidents; supervise critical incidents better and more proactively; revise the Bureau's deadly force policy; and create a policy generally prohibiting firing at a moving vehicle.

Out of nearly one million calls for service during the three-and-one-half-year period, it is important to keep in mind that we reviewed only 32 PPB cases (and two additional investigations), all of which resulted in a shooting or a death. In accordance with our mandate, we did not examine any of the hundreds of thousands of PPB calls for service from 1997 to mid-2000 that were handled without any force, much less without a shot fired or a death. Nor did we re-investigate the cases we reviewed, but rather restricted our analysis, as required by the enabling City Council ordinance, to "policy-related issues."

No set of recommendations can eliminate the need, on occasion, for law enforcement officers to use deadly physical force to defend themselves and others. Following our recommendations, however, will assist the PPB in achieving its goals of enhancing officer safety and minimizing the incidence of officer-involved shootings and in-custody deaths. Following our recommendations will help the Bureau enhance its capacity to extract lessons from its deadly force and in-custody death incidents so that successes in responding appropriately can be replicated and problems remedied.

We offer our findings and recommendations with a view toward helping the Portland Police Bureau achieve the excellence of which it is capable. Based upon the open and constructive manner in which the Bureau has responded to previews of our findings and recommendations, we are optimistic that it will use the contents of this report as a vehicle for enhancing the critical, professional service it provides to the Portland community.

1. Introduction

In 2001 the City of Portland established the Independent Police Review (IPR) Division of the City Auditor's office.[1] Among IPR's responsibilities is recommending policy changes to Portland's City Council and Chief of Police. Early in 2002 the City Council passed an ordinance directing IPR to hire an expert to review closed Portland Police Bureau (PPB) investigations of officer-involved shootings and in-custody deaths to identify "any policy-related issues or quality of investigation issues that could be improved."[2] IPR, assisted by a selection committee, engaged the Police Assessment Resource Center (PARC) to conduct this study.

PARC's review was limited to 34 officer-involved shooting and in-custody death incidents that occurred between January 1, 1997, and June 30, 2000. The latter date was determined by the ordinance's requirement that only "closed" cases be included in the review. For a case to be classified as "closed," all criminal and already-filed civil proceedings had to have been concluded and the two-year statute of limitations for filing civil suits had to have expired. At the time PARC began its review in the fall of 2002, all of the officer-involved shooting and in-custody death incidents that occurred in the three-and-one-half-year period ending June 30, 2000, met the "closed" case criteria.

The 34 cases we reviewed included 30 officer-involved shootings by PPB members and two in-custody deaths involving PPB officers.[3] The two additional cases were separate shootings by deputies from the Clackamas County (OR) Sheriff's Department and the Clark County (WA) Sheriff's Department that occurred in the city of Portland. Since the PPB was required to investigate these shootings, we reviewed the

[1] Ordinance No. 175652, effective July 1, 2001.

[2] Ordinance No. 176317, effective April 12, 2002. "Policy-related issue" is defined by the ordinance as: "a topic pertaining to the Police Bureau's hiring and training practices, the Manual of Policies and Procedures, equipment, and general supervision and management practices, but not pertaining specifically to the propriety or impropriety of a particular officer's conduct." Portland City Code § 3.21.020 (S).

[3] In each of the in-custody death incidents an officer from the Portland School Police, then a separate agency, was also involved in the incident.

PPB investigations of these cases, but not matters relating to the conduct of the deputies from other agencies.

PARC reviewed the following materials on the 34 cases that were included in this study:

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

- The available personal files of the investigating detectives;

- Such after action reports and executive review determinations as were generated;

- City of Portland risk management files for those cases on which a claim was filed;

- Non-privileged portions of City Attorney's files for those cases on which a lawsuit was filed; and

- The files relating to the nomination for and awarding of commendations.

We also met — sometimes on more than one occasion — with numerous officials and others who provided us with information, history, and context.

In City government, we met with the Mayor and staff; staff of the City Council members; the City Auditor; the director and staff of the Independent Police Review Division of the Auditor's office; the City Attorney and several deputy city attorneys; and staff from the Risk Management Bureau.

At the PPB, we met with the Chief; six Assistant Chiefs;[4] a senior officer who was an Assistant Chief during the 1997-2000 time period; the heads of the Detective, Internal Affairs, Management Services, Personnel, Records, and Training divisions; the commanders of and staff at each of the five precincts; the two supervisory sergeants from the Homicide detail; individual Homicide and IA investigators, past and present; Training Division instructors; the risk manager; members of the Employee Assistance Program, including a chaplain and a member of a volunteer peer support group known as the Traumatic Incident Committee (TIC); and other supervisors and staff, sworn and civilian.

We met with the President and Secretary-Treasurer of the Portland Police Association, the union that represents PPB sergeants and officers; and members of the executive board of the Portland Police Command Officers Association, the union that represents lieutenants, captains, and commanders.

Additionally, we met with the Chief Deputy District Attorney and another deputy district attorney, who supervise the review of officer-involved shootings for the Multnomah County District Attorney's Office.

We also met with members of the Citizen Review Committee, and representatives of community groups, activist organizations, and attorneys concerned with issues related to policing.

We gave those we met our contact information and encouraged them to call or e-mail us during the course of this project with additional information and insights that would further our work.

PARC staff also made a number of site visits. We toured each of the five precincts and the areas of the community they serve. We visited the Training Division's

[4] While there were never more than four Assistant Chiefs at one time, there have been six different individuals in Assistant Chief posts during the course of our work in Portland.

main training facility as well as several satellite training locations. We accompanied several officers on ride-alongs in their patrol cars.

We reviewed past and present training manuals, lesson plans, bulletins, and handouts, relating to the issues presented by the cases we reviewed, including, among other things, use of force, vehicle and foot pursuits, traffic stops, critical incident management, suspect restraint and transport, positional asphyxia and sudden death syndrome, and individuals with mental illness. We also reviewed relevant past and present policies of the PPB, comparing them with policies used in other jurisdictions.

Our biggest investment of time was spent reviewing the 34 investigative files and other materials related to those cases. Our review team comprised both PARC staff and consultants, including a retired police executive with 32 years on the job, a senior officer from a major city's police department with 20 years experience, and a police oversight expert. Two team members, always including one of the experienced law enforcement professionals, were assigned to each file so that each could provide an independent assessment. In cases presenting particularly difficult review issues, an additional team member examined the file. The review team met for two full days in May 2003 to discuss the individual cases and emergent themes. Based on our review of the files, we saw no indication that PPB officers used their firearms or other weapons gratuitously.

After we finished our review of the cases we met with the PPB command staff, the City Auditor, and the director of IPR to brief them orally on our principal findings. Drafts of our final report were provided to the Mayor, the PPB, the City Auditor, IPR, and the City Attorney. Drafts were also provided to, and comments sought from, all members of the review team and PARC's three Senior Advisors, who are retired or current police executives or managers — two of whom are involved in monitoring a police department's consent decree or settlement with the U.S. Department of Justice.

After circulating drafts of our report, we met with PPB command staff, managers, and detectives, a representative of the Mayor, a deputy city attorney, the City Auditor,

and the director of IPR to discuss our findings and recommendations, and to respond to concerns about our report. We 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 tried to impinge on our independent judgment as to our findings and recommendations.

As required by the terms of our engagement, the PPB was provided an opportunity to respond to our recommendations — a response that is attached to this report but which we have not reviewed.[5]

Having detailed what we did, we should point out what PARC did not do, in accordance with the ordinance authorizing this study. We did not review any cases other than the 34 that occurred within the prescribed time period. Consistent with the terms of the ordinance that restricted our analysis to "policy-related issues,"[6] we did not re-investigate the 34 cases whose investigations we reviewed; nor do we provide any assessment whether the officers involved in these cases acted lawfully or within PPB policy.

With respect to the matters that were within the scope of our review, our report identifies numerous important issues and contains a comprehensive, empirically supported set of recommendations. In making those recommendations, however, we are keenly aware that our review covered only a tiny portion of the work performed by the PPB.[7]

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[5] The PPB's response was submitted directly to the City Auditor's office, which then attached the PPB's comments to our report. PARC did not see the response until after this report had been completed.

[6] See note 2 and accompanying text.

[7] We looked at 34 incidents in a three-and-one-half-year period during which the PPB responded to nearly one million calls. See Portland Police Bureau 2000 Statistical Report, *Community Policing: Focus on the Future,* which reports that, from 1997 to 2000, the PPB averaged 242,190 dispatched calls for service per year.

We believe that, if followed in good faith, our recommendations will produce benefits for the City and the Police Bureau, as well as for Portland's police officers and the people they serve. We encourage the Bureau to avoid limiting its internal reforms to the specific recommendations made in this report, but rather to embrace the pursuit of best practices in relation to all aspects of its operations.

When we use the term "best practice" or "best practices" throughout this report, we do not necessarily mean a method, policy or procedure that has been adopted by the *majority* of U.S. law enforcement agencies. Rather, a best practice should be understood as representing an emerging or established consensus shared by leading law enforcement professionals and forward thinking civilians who work closely with law enforcement, supported by experience and research. To the extent that the PPB is not engaged in what we recommend as "best practice," does not necessarily mean that its practices or policies are improper, but rather that it can, and should, improve its practice in that area. In those cases where we found deficiencies or potential problems with PPB policies or practices, we expressly identified them as such.

We note, finally, that in reviewing each of the 34 cases presented to us, we never lost sight of the fact that each of the cases involved real people: mothers, fathers, sons, and daughters. Nor did we lose sight of the fact that each of these cases, regardless of any other factors, created tears in the fabric of the lives of civilians and police officers alike.

This report proceeds as follows:

- Chapter 2 presents a statistical overview of the cases we reviewed;
- Chapter 3 examines the PPB's deadly force policy;
- Chapter 4 discusses the PPB's policies and procedures relating to investigations of officer-involved shootings and in-custody deaths;

- Chapter 5 looks at the quality of the investigations of the 34 cases we reviewed and the PPB's presentation of the findings of those investigations;

- Chapter 6 analyzes the PPB's internal review process for officer-involved shootings and in-custody deaths;

- Chapter 7 examines the operational risk management issues presented by the underlying incidents in the cases we reviewed; and

- Chapter 8 discusses relevant practices concerning record-keeping and preservation.

The specific recommendations, which we number according to the chapter in which they are made, are interspersed throughout the report and recapitulated at the end of each chapter.

2. Statistical Overview

PARC reviewed all of the officer-involved shootings and in-custody deaths that occurred in the city of Portland between January 1, 1997, and June 30, 2000. In that three and one-half-year period, there were 32 officer-involved shootings — 30 by the Portland Police Bureau and two by officers from other jurisdictions (specifically, the Clackamas County (OR) Sheriff's Department and the Clark County (WA) Sheriff's Department).[8] In the same period there were two deaths of suspects in the custody of the PPB. With respect to the 30 shooting cases involving PPB officers, we first consider some characteristics of the incidents themselves; second, some characteristics of the suspects; and third, some characteristics of the officers. Thereafter, we provide brief information on the two in-custody death incidents.[9]

The PPB is the local law enforcement agency serving Portland, Oregon — a city with a population of 529,000 that covers 147 square miles.[10] The Bureau employed an average of 993 sworn officers during the period from 1997 to 2000. During that same period, it handled an annual average of 242,190 dispatched calls for service.[11]

[8] The reason for looking at the two shootings by officers from other jurisdictions was to review the investigations done by the PPB on those cases. The fact that the incidents occurred within Portland meant that the PPB was required to investigate them. These two non-PPB cases were excluded from the cases analyzed in this chapter.

[9] As part of this study, PARC collected officer-involved shooting statistics from other law enforcement agencies for the time period examined in this report, with the goal of comparing their rates of officer-involved shootings with Portland's. Unfortunately, these data do not lend themselves to such comparisons for a number of reasons, among them: law enforcement agencies responsible for collecting these data use the phrase "officer-involved shootings" inconsistently; departments use varying criteria for the categories of shooting information (*i.e.,* shots fired by an officer, whether the shots hit or missed the suspect) collected; and some agencies simply do not compile — or make available — useful or complete data. We thus decided not to use the data we collected.

[10] Portland Police Bureau 2000 Statistical Report, *Community Policing: Focus on the Future.*

[11] *Ibid.*

I. Characteristics of the 30 Officer-Involved Shooting Incidents

- Incidents in Which PPB Officers Fired at Suspects ……..…….……30
- Number of Suspects[12] Fired At ……..……..31
- Number of Suspects Killed (and Percentage of Total Suspects) ……...4 (12.9%)
- Number of Suspects Injured (and Percentage of Total Suspects)……...16 (51.6%)
- Number (and Percentage) of Incidents Involving a Suspect with a Gun (19) or Edged Weapon(3)[13]……...…..22 (73.3%)
- Number (and Percentage) of Incidents Involving a Suspect Firing Shots..14 (46.7%)
- Number (and Percentage) of Incidents Where a Suspect Was Charged with Using Vehicle as a Weapon ……...…….……...…3 (10%)
- Number (and Percentage) of Shooting Incidents Involving a Foot Pursuit ...6 (20%)
- Number (and Percentage) of Shooting Incidents Involving a Vehicle Pursuit ……. 5 (17%)

[12] In one case, a PPB officer fired at a vehicle he reported was trying to run him over, shooting a passenger in the front seat; the passenger, as well as the driver, was a suspect in the burglary being investigated. In another case, two PPB officers opened fire on a crashed vehicle containing a shooting suspect. Unknown to the officers, the vehicle also contained a passenger who narrowly escaped injury and who was not charged with a crime. (This latter passenger has not been counted as a suspect.)

[13] This category refers to cases where a gun or edged weapon was recovered. It does not necessarily mean that the suspect used or brandished the weapon against officers. It also includes cases where the suspect discarded the weapon before the first shot by an officer was fired.

Table 1: Shooting Incidents, by Year

	1997	1998	1999	2000 (thru June 30)	Total 1/1/97-6/30/00
Number of Shooting Incidents	9	9	10	2	30
Shots Fired by Officers at Persons	25	47	117[14]	17	206
Suspects Injured by Shots Fired	7	4	5	0	16
Suspects Killed by Shots Fired	1	2	0	1	4

As noted in Chapter 1, the focus of our analysis was on "policy-related issues," as required by the City Council ordinance authorizing the review. Consistent with the spirit of that requirement, we have omitted the names of the officers and suspects involved in our discussions of cases in this report. We do, however, provide several specifics concerning each of the 30 cases in Table 2 so that our readers have a better understanding of the nature of these 30 incidents. The focus in this and other sections of the report is to provide information about the cases we reviewed as a whole, rather than about any case individually.[15]

Table 2 shows that all but one[16] of the suspects were alleged[17] by the PPB to have either possessed a weapon or sought to take a weapon away from an officer. Specifically,

[14] Two incidents accounted for the high number of rounds fired in 1999. In both incidents, PPB officers were returning gunfire from suspects. In one incident officers fired 40 shots to the suspect's two shots, and in the other they fired 33 rounds to the suspect's 10.

[15] The incidents in Table 2 are presented by type of weapon used by the suspect.

[16] In this case, the officers saw the suspect reaching toward his waistband.

[17] Some of these allegations were disputed.

19 possessed guns; three, edged weapons; three, vehicles; two were alleged to have sought to take away a weapon from an officer; one, a blunt object; and one, although actually unarmed, possessed an object that looked like a gun. The table also shows that 14 of the 19 (74%) suspects identified as possessing a gun fired it — firing, in the aggregate, at least 86 shots.[18]

[18] In one incident, officers counted somewhere between three and seven shots; in another, they counted one to two shots. For the purposes of the total number of shots above, we included the minimum estimated number of shots.

Table 2: Officer-Involved Shootings, Case Descriptions

Suspect's Weapon	Shots Fired by Suspect?	Number of Shots Fired by Suspect	Number of Shots Striking Officers	Number of Shots Fired by Officers	Number of Shots Striking Suspect
None	N/A	N/A	N/A	1	0
Attempted Take-Away	No	0	N/A	1	1
Attempted Take-Away	No	0	N/A	1	1
Blunt Object	N/A	N/A	N/A	2	2
Edged Weapon	N/A	N/A	N/A	1	0
Edged Weapon	N/A	N/A	N/A	2	2
Edged Weapon	N/A	N/A	N/A	4	2
Apparent Gun	N/A	N/A	N/A	3	2
Pistol	No	0	0	1	1
Pistol	No	0	0	1	1
Pistol	Yes	3	3	1	1
Pistol	Yes	9	0	4	2
Pistol	Yes	6	0	8	0
Pistol	Yes	1	1	1	0
Pistol	Yes	2	0	8	2
Pistol	No	N/A	N/A	1	0
Pistol	Yes	3 to 7	0	11	1
Pistol	Yes	5	1	15	2 to 3
Pistol	Yes	2	1	12	2
Pistol	Yes	2	0	40	3
Pistol	No	3	N/A	4	0
Pistol	Yes	1 to 2	0	5	0
Pistol	Yes	6	0	12	0
Pistol	Yes	8	0	5	2
Rifle	Yes	25	8	20	1
Rifle	Yes	10	2	33	0
Shotgun	No	0	0	1	1
Vehicle	N/A	N/A	N/A	1	1
Vehicle	N/A	N/A	N/A	6	0
Vehicle	N/A	N/A	N/A	1	0

II. Characteristics of the Suspects

Table 3 analyzes the suspects in the 30 officer-involved shooting cases, and various incident characteristics relating to those suspects (injured, killed, fired a gun, weapon recovered, and vehicle as a deadly weapon), by race and ethnicity. The statistics in Table 3, standing alone, provide no reliable basis for determining whether race or ethnicity was a factor in these 30 officer-involved shootings. However, our in-depth case-by-case analysis of the files on these cases and on the two in-custody deaths revealed no indications of racial or ethnic bias.

Table 3: Suspects Involved in PPB Officer Shootings, by Race/Ethnicity

	White	African-American	Latino	Asian	Totals
Suspects Fired Upon by PPB Officers	20 (64.5%)	4 (12.9%)	5 (16.1%)	2 (6.5%)	31 (100%)
Number of Suspects Injured	11 (73.3%)	1 (6.7%)	3 (20%)	0 (0%)0	15 (100%)
Number of Suspects Fatally Injured	3 (75%)	1 (25%)	0 (0%)	0 (0%)	4 (100%)
Suspects Firing a Gun	8 (57.1%)	2 (14.3%)	3 (21.4%)	1 (7.1%)	14 (100%)
Suspects from Whom Weapons Were Recovered[19]	Gun: 11 Edged Weapon: 3 Blunt Object: 1 **Total: 15** (65.2%)	Gun: 3 Edged Weapon: 0 Blunt Object: 0 **Total: 3** (13%)	Gun: 3 Edged Weapon: 0 Blunt Object: 0 **Total: 3** (13%)	Gun: 2 Edged Weapon: 0 Blunt Object: 0 **Total: 2** (8.7%)	Gun:19 Edged Weapon:3 Bl. Obj.: 1 **Total: 23** (100%)
Suspects Allegedly Using a Vehicle as a Deadly Weapon	1 (33.3%)	1 (33.3%)	1 (33.3%)	0 (0%)	3 (100%)
Percentage of Portland's Population	77.9%	6.6%	6.8%	6.3%	97.6%[20]

[19] Possession of a weapon, in and of itself, does not mean that a shooting is necessary or justified.

[20] The racial groups "White," "African-American" ("Black" in census parlance), "Latino" ("Hispanic" per the census), and "Asian" make up 97.6 percent of Portland's population. The remaining 2.4 percent of the population is made up of persons who are "native Hawaiian or other Pacific Islanders," multi-racial, or

Table 4 shows that suspect intoxication was a common factor in many of the shooting incidents. Of the 30 cases involving shots fired by PPB officers, 16 involved at least one suspect reported to be under the influence of drugs or alcohol. Overall, 55 percent of the suspects were intoxicated on one or more substances.

Table 4: Intoxication of Suspects Involved in PPB Officer Shootings

Intoxicant	Number of Suspects Intoxicated	Percentage of Suspects Intoxicated
Alcohol	11	35.5%
Controlled Substances (incl. controlled substances in combination with alcohol)	6	19.4%
No Evidence of Intoxication in Investigative File	14	45.2%

Table 5 looks at the suspects by age and race. For the time period we studied, white suspects were, on average, 15 years older than African-American suspects, averaging 34 to the latter's 19. Latinos and Asians fell somewhere in between.

Table 5: Mean/Median Age of Suspects Involved in PPB Officer Shootings, by Race/Ethnicity

	White	African-American	Latino	Asian	All Races/ Ethnicities
Mean/Median Age[21]	34.3/34	19.3/19	27.2/28	22/22	30.7/28.5

- Gender of Suspects……30 males, 1 female

other races. U.S. Census Bureau, Census 2000 Summary File 1, Matrices P3, P4, PCT 4, PCT 8, and PCT 11.

[21] One African-American suspect's age was unknown.

III. Characteristics of the PPB Officers

- Total Number of Shooting Incidents with Involved[22] PPB Officers……..30
- Total Number of PPB Officers Involved in Shooting Incidents……..48[23]
- Incidents in Which a PPB Officer Was Killed……..2
- Total Number of PPB Officers Killed……...2
- Incidents in Which a PPB Officer Was (Non-Fatally) Wounded by Gunfire……5[24]
- Total Number of Officers (Non-Fatally) Wounded by Gunfire…….....6[25]
- Off-Duty Shooting Incidents……1
- Mean/Median PPB Experience of Involved PPB Officers…….……7.4/5.3 years
- Mean/Median Age of Involved PPB Officers……...…...33.8/31.4

Two PPB officers were killed in these 30 incidents, and five were injured by gunfire. An officer from the Gresham Police Department was also wounded in one of these incidents.

Ninety percent of the 48 involved officers were white. Their average age was 34 and their median age was 31. All were male. Half of the officers involved in shootings had been on the force less than 5.3 years, and 65 percent (31 of 48) had been with the PPB for less than seven years. The mean length of service with the PPB, however, was 7.4 years, influenced by the fact that a small number of involved officers had many years of service.

[22] Consistent with the PPB policies and recordkeeping practices, we deemed an officer to be "involved" in one of the shooting incidents we studied if he fired a gun at a person.

[23] Two officers, each involved in two different shootings, have been counted twice.

[24] Four incidents involved five PPB officers being injured by gunshots; one incident involved a Gresham Police Department officer who was shot**.**

[25] See note 24 above.

Table 6: Officers Involved in Shooting Incidents, Years of PPB Service

1 to 3	3 to 5	5 to 7	7 to 9	9 to 11	11 to 15	15 to 20	20+	Mean/ Median
10	11	10	5	2	2	5	3	7.4/5.3

Table 7: PPB Officers Involved in Shootings, by Race/Ethnicity

	White	African-American	Latino	Asian	Native American	All Races/ Ethnicities
Number (and Percentage)	43 (89.6%)	1 (2.1%)	2 (4.2%)	1 (2.1%)	1 (2.1%)	48 (100%)
Mean/Median Age	34/31.8	37.9/37.9	30.4/30.4	30.5/30.5	30.2/30.2	33.8/31.4
Racial breakdown of Total PPB Force[26]	89.5%	3.3%	2%	4.5%	0.7%	100%

In the pie chart and in Table 8, involved officers are analyzed by their units of assignment. The cases are classified by the assignment of the officers who fired their guns, not by the location of the shooting. Northeast Precinct (8 incidents, 27%), followed by East (6, 20%) and Central (6, 20%), were involved in two thirds of the incidents. The highly trained Special Emergency Reaction Team (SERT), which is designed to respond to situations with barricaded suspects and other high-risk and emergency situations, was involved in only two (7%) of these 30 officer-involved shootings.

[26] Averages for the reviewed fiscal years (1997-98, 1998-99, 1999-2000), including sworn and civilian PPB personnel, based on information provided by Portland's Bureau of Human Resources.

Units Involved in PPB Shooting Incidents

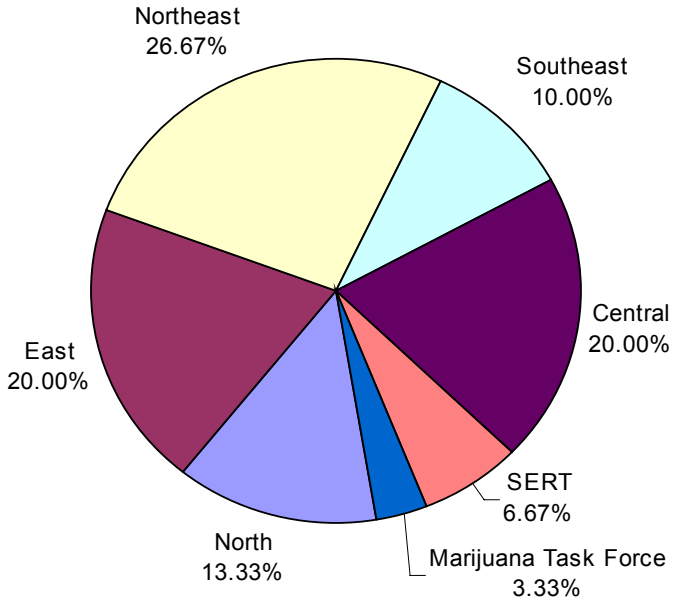

Table 8: Units of Shooting, Involved PPB Officers

Unit	Number of Shooting Incidents Involving Unit	Percentage of All Shooting Incidents	Number of Officers from Unit Involved in Shootings[27]	Percentage of All Officers Involved in Shootings
North	4	13.3%	9	18.7%
East	6	20.0%	7	14.6%
Northeast	8	26.7%	12	25.0%
Southeast	3	10.0%	3	6.2%
Central	6	20.0%	7	14.6%
SERT	2	6.7%	8	16.7%
Marijuana Task Force	1	3.3%	2	4.2%
Total	**30**	**100%**	**48**	**100%**

[27] Includes two officers involved in more than one shooting.

IV. In-Custody Deaths

There were two in-custody deaths, both involving men who were intoxicated, one on cocaine, the other alcohol. The latter person also suffered from mental illness. One was African-American, the other white. Each struggled with large numbers of officers — six and nine, respectively — before collapsing. The cause of death for one was "cocaine psychosis, with excited delirium, aggravated by positional asphyxiation and exertion." The cause of death for the second case was "psychosis with excited delirium and cardio-respiratory arrest during restraint."

3. Portland's Deadly Force Policy

As noted in Chapter 1, one of our primary responsibilities is to assess the PPB's policies in light of national best practices and to offer suggestions for improvement. We begin that analysis by turning to the PPB's policy regarding officers' use of deadly force. For the time period we studied (January 1, 1997 to June 30, 2000), there were two versions of this policy. The first version, General Order 1010.10 (September 13, 1993), was in effect from the beginning of our review period through May 9, 1998. A copy of this General Order is set forth in the Appendix at page 15. The second version, effective May 10, 1998, is set forth in Section 1010.10 of the PPB's Manual of Policy and Procedure (2002) ("PPB Manual") and remains in effect today. A copy of the current version of Section 1010.10 is set forth in the accompanying Appendix at page 1.

Our first concern in reviewing agency rules is whether the policy complies with constitutional requirements and federal, state, and local law. In that regard, we found that both versions of the PPB's deadly force policy fall well within the ambit of the applicable constitutional and legal requirements. It is not enough, however, to comply with minimum legal requirements, as the PPB explicitly recognizes.[28] Rather, the Bureau's deadly force policy must be assessed in light of nationwide best practices. It was here that we found room for improvement.[29]

I. Mission Statement and Definitions

A. Mission Statement

Every police agency trains its officers to value human life and to regard deadly force as a grave measure to be employed only in the rarest of circumstances. The PPB

[28] PPB Manual, § 1010.10 at 404 (2002).

falls squarely within this tradition. One of the PPB's training handouts notes, "The law values life *above all things* and seeks to avoid forceful encounters between citizens. . . . [T]his concept has governed since the middle ages."[30]

A growing number of police agencies have decided to memorialize these ideas in their deadly force policies themselves, usually in the form of a preamble or mission statement. Though not necessary from a legal standpoint, such mission statements communicate both to the community and to police officers that the preservation of human life is at all times a central tenet of the police agency.

Neither the former nor current version of the PPB's deadly force policy contains such a preamble or mission statement. Instead, the focus in the current preamble is on officers' authorization to use deadly force in certain circumstances: "The Bureau recognizes that members may be required to use deadly force when their lives or the life of another is jeopardized by the actions of others."[31] While this is certainly true, the PPB should consider revising its policy to place deadly force in a broader context, one that underscores that deadly force is to be used in extremely limited circumstances.

There are many excellent examples to draw from. Some, such as the use of force/deadly force policy for the Louisville, Kentucky Metro Police Department, are brief and to the point:

> It is the intent of the Louisville Metro Police Department that all members recognize the importance of human life, respect basic human rights, and have an intolerant attitude towards abusive treatment of all persons. Bearing this in mind, officers' use of force will be value driven, utilizing

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[29] Our recommendations are based upon our review of the PPB's policies in the context of national best practices. Thus, unless we note otherwise, our recommendations do not arise from any evaluation of how PPB officers performed in the cases we reviewed.

[30] PPB Lesson Plan: *Kuykendall, Use of Force* (1998).

[31] PPB Manual, § 1010.10 at 404 (2002).

only the force reasonable under the circumstances so as to minimize the chance of injury to themselves and others. . . .

. . . .

Deadly force, as with all uses of force, may not be resorted to unless other reasonable alternatives have been exhausted or would be clearly ineffective, or other exigent circumstances exist.[32]

The Philadelphia Police Department's deadly force policy provides some greater detail:

A. The Philadelphia Police Department recognizes the value of all human life and is committed to respecting the dignity of every individual. The primary duty of all police officers is to preserve human life.

B. The most serious act in which a police officer can engage is the use of deadly force. The power to carry and use firearms in the course of public service is an awesome responsibility. Only the minimal amount of force necessary to protect human life should be used by all officers.

C. Above all, the safety of the public and the officer must be the overriding concern whenever the use of firearms is considered.[33]

A more detailed mission statement may be found in the Los Angeles Police Department's (LAPD's) recently revised deadly force policy:

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[32] Louisville Metro Police Department, Standard Operating Procedure 9.1 (April 2003). A copy of this policy is set forth in the Appendix at page 115.

[33] Philadelphia Police Department, Directive 10 (January 2001). A copy of this policy is set forth in the Appendix at page 190.

> PREAMBLE TO THE POLICY ON THE USE OF FIREARMS. The use of a firearm is in all probability the most serious act in which a law enforcement officer will engage. It has the most far-reaching consequences for all of the parties involved. It is, therefore, imperative not only that the officer act within the boundaries of legal guidelines, ethics, good judgment, and accepted practices, but also that the officer be prepared by training, leadership, and direction to act wisely whenever using a firearm in the course of duty.
>
> A reverence for the value of human life shall guide officers in considering the use of deadly force. While officers have an affirmative duty to use that degree of force necessary to protect human life, the use of deadly force is not justified merely to protect property interests. . . . [34]

Although the PPB, as an organization, already holds true to each of the values quoted above, the Bureau would benefit from memorializing these ideas in its policies.

Recommendation 3.1: The PPB should add a preamble or mission statement to its written deadly force policy, underscoring the Bureau's reverence for the value of human life and its view that deadly force is to be used only where no other alternatives are reasonably available.

B. Definition of Deadly Force

The PPB's current policy defines deadly force as "that physical force that under the circumstances in which it is used is readily capable of causing death or serious

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[34] Los Angeles Police Department Manual of Policy and Procedure, Vol. 1, § 556 (2002). A copy of this policy is set forth in the Appendix at page 87.

physical injury . . . ."[35] Elsewhere in the policy, the PPB appropriately notes that deadly force is not necessarily limited to firearms. The preamble states:

> The use of statutorily defined deadly weapons, barricades and vehicle ramming, constitutes deadly physical force. Also, depending upon how they are used, flashlights, batons, body parts, and other statutorily defined dangerous weapons may constitute deadly physical force.[36]

These definitions are well within the ambit of state and federal law. Still, there is room for improvement. First, the PPB should combine both discussions into a single, formal definition so that no aspects of the definition are overlooked — a distinct possibility given that the current policy spans more than 12 single-spaced pages in the PPB's Manual.

Second, the policy should provide officers with more specific guidance on when strikes with impact weapons amount to deadly force. Over the past decade, a growing number of police agencies have clarified their policies on this point. The first such change we are aware of came from the Los Angeles County Sheriff's Department, which modified its use of force policy in 1992 to address head strikes with impact weapons. The policy reads:

> **Unreasonable force.** Department members shall use only that force which is objectively reasonable. Unreasonable force is that force that is unnecessary or excessive given the circumstances presented to Department members at the time the force is applied. Unreasonable force is prohibited. The use of unreasonable force will subject Department members to discipline and/or prosecution.

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[35] PPB Manual, § 1010.10 at 405 (2002).

[36] *Id.* at 403-04.

> *Head strikes with an impact weapon are prohibited unless circumstances justify the use of deadly force***.** (Emphasis added.)[37]

The Metropolitan Police Department in Washington, D.C. takes a slightly broader view in its definition of deadly force, which was revised as part of a 2001 settlement agreement with the Justice Department:

> Deadly Force — any use of force likely to cause death or serious physical injury, including but not limited to the use of a firearm or a strike to the head with a hard object.[38]

Other agencies have come to recognize that impact weapons can have lethal consequences if aimed at other vital areas as well. For example, the Denver Police Department states in its policy:

> The head or neck shall not be intentionally struck with [an] impact tool/device, unless the officer is justified in using deadly force.[39]

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[37] Los Angeles Sheriff's Department Manual of Policy and Procedure, § 3-01/025.10 (2003). A copy of this policy is set forth in the Appendix at page 90.

[38] Metropolitan Police Department General Order 901.07 at 2 (2002). A copy of this policy is set forth in the Appendix at page 121.

[39] Denver Police Department Operations Manual, § 105.00 at 100-103 (November 2002). A copy of this policy is set forth in the Appendix at page 56.

The Denver policy also provides officers with two specific examples in which deadly force applications of impact weapons may be reasonable:

(a) Controlling a suspect who has disarmed an officer and the officer reasonably believes that the suspect is about to use the firearm against the officer or another.
(b) Controlling a suspect who is armed with a knife or other deadly weapon and due to the suspect's close proximity, the officer reasonably believes that the suspect is threatening the officer with imminent death or serious bodily injury.

Id. at 100-104.

The Louisville Metro Police Department's deadly force policy contains a similar restriction:

> Because of the potential for death or serious injury, officers will avoid intentional strikes to the head, neck, throat, or clavicle with an impact weapon of any sort, unless deadly force is justified.[40]

The Phoenix Police Department takes a similarly broad view in its policy:

> Officers will not purposely strike or jab suspects with an impact weapon on the head, neck, sternum, spine, lower abdomen, groin, or kidneys unless faced with a deadly force situation.[41]

Recommendation 3.2: The PPB should expand its written deadly force policy to provide that certain uses of force, such as strikes to the head or other vital areas with impact weapons, may not be used unless the officer is justified in using deadly force.

By and large, these changes memorialize what the PPB has been training its officers for years. However, by stating the matter in policy, the PPB offers guidance on what practices are actually forbidden, and not merely discouraged. In addition, a policy provides a more solid basis for discipline, should it prove necessary.

II. Addressing Specific Uses of Deadly Force or Threatened Deadly Force

Like most other agencies, the PPB discusses in its policy particular applications of its deadly force rule. The two identified in the PPB's policy — fleeing felons and shots fired at or from moving vehicles — while probably legally sound, do not measure up to

[40] Louisville Metro Police Department, Standard Operating Procedure (April 2003).

[41] Phoenix Police Department Operations Order 1.5 at 7 (2002). A copy of this policy is set forth in the Appendix at page 203.

national best practices. In addition, the PPB should amend its policies to include two issues not addressed in its policies: (1) avoiding tactics that may unnecessarily expose officers to situations likely to require a deadly force response; and (2) the decision to draw or point a firearm at civilians. We address each of these matters in turn.

A. Fleeing Felon Rule

In 1985, the Supreme Court ruled in *Tennessee v. Garner* that the Fourth Amendment to the United States Constitution allows officers in some circumstances to use deadly force to stop a fleeing felon. Specifically, the Court held:

> Where the officer has probable cause to believe that the suspect poses a threat of serious physical harm, either to the officer or to others, it is not constitutionally unreasonable to prevent escape by using deadly force. Thus, if the suspect threatens an officer with a weapon or there is probable cause to believe that he has committed a crime involving the infliction or threatened infliction of serious physical harm, deadly force may be used if necessary to prevent escape, and if, where feasible, some warning has been given.[42]

Garner does not require that the suspect pose an immediate, or even short-term, threat to the community if allowed to escape. *See, e.g., Forrett v. Richardson,* 112 F.3d 416, 420 (9th Cir. 1997) (noting that *Garner* does not require the suspect to pose "an *immediate* threat to the officers or others at the time of the shooting" [emphasis added]).

[42] 471 U.S. 1, 11-12.

Oregon's fleeing felon statute, likewise, does not require that the fleeing felon present an imminent threat.[43] Nor does the PPB's own deadly force policy, which provides that the use of deadly force may be used "under the following circumstances":

> a. . . . .
>
> b. A member may use deadly force to effect the capture or prevent the escape of a suspect where the member has probable cause to believe that the suspect poses a significant threat of death or serious physical injury to the member or others.
>
> c. If feasible, some warning has been given.[44]

The PPB's policy does not define what constitutes a "significant threat" by the suspect[45] and does not address issues relating to the imminence of the threat — *i.e.* whether there are reasonable grounds for believing that death or serious injury will occur if there is any delay in apprehending the suspect. Indeed, interviews with PPB officials revealed different interpretations, some that embraced imminent threat requirement and some that did not.

It is widely recognized that deadly force should be used only as a last resort. Accordingly, a growing number of law enforcement agencies have gone beyond the requirements of state and federal law and required their officers to hold fire unless they

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[43] Oregon Revised Statutes, § 161.239. A copy of this statute is set forth in the Appendix at page 33.

[44] PPB Manual, § 1010.10 at 404 (2002).

[45] Unlike *Garner* and the state statute, the PPB policy does not provide officers with any guidance regarding the nature of the threat to be stopped. *Garner* cited two specific examples when a suspect may be viewed as "pos[ing] threat of serious physical harm, either to the officer or to others," namely: (1) where "the suspect threatens an officer with a weapon" and (2) where "there is probable cause to believe that [the suspect] has committed a crime involving the infliction or threatened infliction of serious physical harm." *Garner,* 471 U.S. 1, at 11-12. Oregon state law provides similar guidance, stating, for example, that an officer may use deadly force to prevent the escape of a person suspected of committing "a felony or an attempt to commit a felony involving the use or threatened imminent use of physical force." Oregon Revised Statutes § 161.239(a).

have probable cause to believe that the fleeing felon presents an imminent threat to others. For example, in 1995, the U.S. Justice and Treasury departments, revised their deadly force policies to require an imminence requirement for fleeing felons. The Department of Justice policy states:

> Fleeing felons. Deadly force may be used to prevent the escape of a fleeing subject if there is probable cause to believe: (1) the subject has committed a felony involving the infliction or threatened infliction of serious physical injury or death, and (2) the escape of the subject would pose an imminent danger of death or serious physical injury to the officer or to another person.[46]

The Treasury Department's policy contains the same restrictions. These policies effectively forbid federal agents from firing upon fleeing felons unless there is probable cause to believe "the escape of the subject would pose an *imminent* danger of death or serious physical injury to the officer or to another person."[47]

The Phoenix Police Department has approached the issue in a slightly different manner, focusing on the perceived consequences of failing to apprehend the suspect immediately. Its policy states in relevant part:

> Officers may use deadly force under the following circumstances:
>
> . . . .
>
> To prevent the escape of a subject whom the officer has probable cause to believe [1] has committed an offense involving the infliction or threat of

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[46] U.S. Department of Justice, Office of Investigative Agency Policies, Resolution 14, Attachment A (Oct. 16, 1995).

[47] *See* Bolgiano, Leach, Smith, & Taylor, *Defining the Right of Self-Defense: Working Toward the Use of a Deadly Force Appendix to the Standing Rules of Engagement for the Department of Defense*, 31 U. Balt. L. Rev. 157, 170 (2002) (noting that the revised policies apply to the FBI, the U.S. Marshals Service, the Bureau of Prisons, the Bureau of Alcohol, Tobacco and Firearms, the Drug Enforcement Administration, the Secret Service, and the Customs Service). (Emphasis added.)

> serious physical injury or death and [2] *is likely to endanger human life or cause serious injury to another unless apprehended without delay*.
>
> . . . .
>
> Deadly force is utilized as a last resort when other measures are not practical under the existing circumstances. (Emphasis added.)[48]

A similar formulation is used by the LAPD, whose deadly force policies have undergone substantial revision pursuant to a federal consent decree. The LAPD's fleeing felon rule states:

> An officer is authorized to use of deadly force when it reasonably appears necessary:
>
> . . . .
>
> To apprehend a fleeing felon for a crime involving serious bodily injury or the use of deadly force where there is a *substantial risk that the person whose arrest is sought will cause death or serious bodily injury to others if apprehension is delayed*.
>
> . . . .
>
> Deadly force shall only be exercised when all reasonable alternatives have been exhausted or appear impracticable.[49]

The Metropolitan Police Department in Washington, D.C. likewise has substantially tightened its fleeing felon rule as part of a settlement with the Department of Justice. The revised policy states in relevant part:

> Members may use deadly force to apprehend a fleeing felon ONLY when every other reasonable means of effecting the arrest or preventing the escape has been exhausted AND,

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[48] Phoenix Police Department Operations Order 1.5, at 10 (2002).

[49] Los Angeles Police Department Manual of Policy and Procedure, Vol. 1, § 556.40 (2002). (Emphasis added.) A copy of this policy is set forth in the Appendix at page 87.

a. The suspect fleeing poses an *immediate* threat of death or serious bodily harm to the member or others; OR

b. There is probable cause to believe the crime committed or attempted was a felony, which involved an actual or threatened attack which could result in death or serious bodily harm; AND

(1) There is probable cause to believe the person fleeing committed or attempted to commit the crime, AND

(2) Failure to *immediately* apprehend the person places a member or the public in *immediate* danger of death or serious bodily injury; AND

(3) The lives of innocent persons will not be endangered if deadly force is used.[50]

The last requirement in the Metropolitan Police Department's policy — that officers not use deadly force in a way that jeopardizes the safety of the public — is a best practice that the PPB should adopt.[51]

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[50] Metropolitan Police Department General Order 901.07, at 7 (2002). (Emphasis added.)

[51] Other agencies use similar language elsewhere in their policies. For example, the Denver Police Department states in its policies: "Officers will not discharge firearms . . . where there is a likelihood of serious injury to persons other than the person to be apprehended." Denver Police Department Operations Manual, 12, at 100-111 to 100-112 (November 2002). In addition, the LAPD's policy manual states:

> PROTECTION OF GENERAL PUBLIC. Regardless of the nature of the crime or the justification for firing at a suspect, officers must remember that their basic responsibility is to protect the public. Officers shall not fire under conditions that would subject bystanders or hostages to death or possible injury, except to preserve life or prevent serious bodily injury. Firing under such conditions is not justified unless the failure to do so at the time would create a substantial immediate threat of death or serious bodily injury.

Although the PPB's fleeing felon policy does not contain any imminent threat requirement, the PPB may well be following this rule in practice. In most cases we reviewed, it appeared that officers held their fire unless they perceived themselves or others to be in imminent danger.

Recommendation 3.3: The PPB should revise its deadly force policy to prohibit officers from using deadly force to stop a fleeing felony suspect unless they have probable cause to believe that the suspect (1) has committed an offense involving the actual or threatened infliction or threat of serious physical injury or death, and (2) is likely to endanger human life or cause serious injury to another unless apprehended without delay. In addition, the policy should make clear that even in those circumstances, deadly force should not be used where (1) other means of apprehension are reasonably available to the officers, or (2) it would endanger the lives of innocent bystanders.

B. Shots Fired at Vehicles

Another special circumstance addressed in the PPB's policies is gunfire by PPB officers at or from moving vehicles. The current deadly force policy states the rule as follows:

> A member justified in using deadly physical force may shoot at, or from, a moving vehicle if, in the totality of the situation, the additional risks are clearly outweighed by the need to use deadly physical force.[52]

This rule does not comport with best practice for a number of reasons, including the fact that it fails to provide officers with sufficient guidance.

Los Angeles Police Department Manual of Policy and Procedure, Vol. 1, § 556.30 (2003). A copy of this policy is set forth in the Appendix at page 87.

[52] PPB Manual, § 1010.10 at 404 (2002).

Unlike other aspects of the PPB Manual we have addressed thus far, our concerns about this particular policy turn largely upon our review of individual shooting cases we reviewed. We discuss these cases, and our recommendations for revising the PPB's policy on this subject, in Chapter 7. (See Recommendation 7.15.)

C. Avoiding Actions That May Unnecessarily Give Rise to Deadly Force Situations

As we discuss in depth in Chapter 7, PPB officers in the cases we reviewed often ended up using significant or deadly force because they did not approach a critical incident as cautiously as was warranted. This lack of caution frequently led to compromises of officer safety and the increased likelihood of circumstances in which the use of deadly force was justified.

These instances of responding to critical incidents in an unnecessarily high-risk manner raise the question of whether and how a police agency can hold officers accountable for failing to follow or even consider reasonable alternatives that were available to them. At present, the PPB's principal option — as is the case in most agencies — is to determine that an officer has violated a broad, catch-all policy requiring officers to meet minimum standards of performance. The PPB's catch-all policy, entitled "Unsatisfactory Performance," set forth in Manual Section 315.30, states in pertinent part:

> Members shall maintain sufficient competency to properly perform their duties and assume the responsibilities of their positions. Members shall perform their duties in a manner that will maintain the highest standards of efficiency in carrying out the functions and objectives of the Bureau. Unsatisfactory performance may be demonstrated by a lack of knowledge of the application of laws required to be enforced; an unwillingness or

> inability to perform assigned tasks; the failure to conform to work standards established for the rank, grade or position; the failure to take appropriate action on the occasion of a crime, disorder, or other condition deserving police attention . . . .

The Philadelphia Police Department, however, has taken a more directed approach, specifically addressing officer conduct leading up to the use of deadly force. After identifying particular situations in which deadly force is appropriate or inappropriate, Philadelphia's policy goes on to state:

> Police officers should ensure their actions do not precipitate the use of deadly force by placing themselves or others in jeopardy by taking unnecessary, overly aggressive, or improper actions.
>
> NOTE: Retreating or repositioning is not a sign of weakness or cowardice by an officer; it is often a tactically superior police procedure rather than the immediate use of force.[53]

It is premature to determine that this policy constitutes best practice. We have not seen similar policies from other agencies and not enough time has elapsed to assess how well this rule has worked for Philadelphia versus the traditional alternative of holding officers liable for failing to meet minimum performance standards. Nonetheless, we offer this policy for the PPB's consideration and further study.

Recommendation 3.4: The PPB should consider whether it would be appropriate to revise its written deadly force policy to expressly require officers to refrain from taking actions that unnecessarily lead to the use of deadly force.

[53] Philadelphia Police Department, Directive 10 (January 2001).

D. Drawing and Pointing Firearms

The PPB's former and current deadly force policies do not provide officers with any guidance regarding when it is appropriate to draw and point their weapons. Although the mere drawing of a firearm, of course, does not amount to deadly force, it may substantially increase the likelihood that deadly force will result, including increasing the risks of events such as accidental discharges or disarming of the officer.

An increasing number of agencies are adopting formal rules identifying when it is appropriate to draw or point a firearm. A key purpose in adopting a formal rule is to provide officers with concrete guidelines and, if necessary, to establish a basis for accountability for deviations from the guidelines.[54]

The LAPD's policy on drawing and pointing weapons provides:

> Unnecessarily or prematurely drawing or exhibiting a firearm limits an officer's alternatives in controlling a situation, creates unnecessary anxiety on the part of citizens, and may result in an unwarranted or accidental discharge of the firearm. Officers shall not draw or exhibit a firearm unless the circumstances surrounding the incident create a reasonable belief that it may be necessary to use the firearm in conformance with this policy on the use of firearms.[55]

The Los Angeles Board of Police Commissioners in 1977 adopted the following interpretation of the policy quoted above:

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[54] Although the cases we reviewed did not indicate that PPB officers were too quick to draw their weapons or that they pointed their weapons recklessly or negligently, we were unable to analyze this subject in any depth because the PPB's investigative files generally did not identify when officers drew or pointed their weapons. In addition, we were not asked to examine cases other than officer-involved shootings or in-custody deaths in which officers drew or pointed their weapons.

[55] Los Angeles Police Department Manual of Policy and Procedure, Vol. 1, § 556.80 (2002). A copy of this policy is set forth in the Appendix at page 87.

> An officer's decision to draw or exhibit a firearm should be based on the tactical situation and the officer's reasonable belief there is a substantial risk that the situation may escalate to the point where deadly force may be justified. When an officer has determined that the use of deadly force is not necessary, the officer shall, as soon as practicable, secure or holster the firearm."[56]

The Cincinnati Police Department likewise provides officers with detailed guidance in its firearms policy:

> At such time as a police officer perceives what he interprets to be a threat of loss of life or serious physical harm to himself or others at the hands of another, he has the authority to display a firearm, with finger outside the trigger guard and have it ready for self-defense. The finger is only to be placed on the trigger when on target and ready to engage a threat.[57]

The Metropolitan Police Department in Washington takes a similar approach:

> No member shall draw and point a firearm at or in the direction of a person unless there is a reasonable perception of a substantial risk that the situation may escalate to the point where lethal force would be permitted. When it is determined that the use of lethal force is not necessary, as soon as practicable, firearms shall be secured or holstered.[58]

The Metropolitan Police Department's policies, however, go one step further in seeking to better manage its officers' use of firearms. Pursuant to the agency's 2001 settlement

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[56] *Ibid.*

[57] Cincinnati Police Department Manual of Rules and Regulations, § 12550 (2003).

[58] Metropolitan Police Department General Order 901.07, at 4 (2002).

agreement with the Department of Justice, it also requires officers to "complete a [Use of] Force Incident Report immediately following the drawing of and pointing a firearm at or in the direction of another person.[59]

The policies of the Los Angeles Police Department and of the Metropolitan Police Department with respect to limiting the drawing and pointing of weapons to situations in which the use of deadly force is justified are consistent with the training given PPB officers. The translation of that training into policy would reinforce the principles taught by the Training Division without compromising officer safety or undermining officers' legitimate law enforcement objectives.

Recommendation 3.5: The PPB should revise its deadly force policy to clearly articulate when officers may draw or point their firearms and when they should re-holster them. In addition, the PPB should require officers to report in writing each instance in which they draw and point a firearm at another person.

E. Use of Force Reporting

During the course of our study we learned that the PPB does not require officers to report their use of force in a uniform manner or even in a manner that facilitates the collection and analysis of use of force data. Instead, the PPB merely requires officers to describe any force they used in the narrative portion of any arrest or supplemental reports.

Best practice dictates that if a law enforcement agency is to effectively manage its officers' use of force — then it must be able to track how often force is used, and under what circumstances. The most efficient and fair manner of tracking this information is to require the involved officers (or their immediate supervisors) to note the use of force on a separate form, typically called a Use of Force Report so that the information is logged in

[59] Metropolitan Police Department Circular, Use of Force Incident Report (2002). A copy of this circular is set forth in the Appendix at 131. *See generally Memorandum* of Agreement between Metropolitan Police

a uniform, consistent manner that allows for easier tracking and analysis of use of force data. Such data should then be incorporated into a computerized early warning system. Sample Use of Force Reports from the LASD and the Philadelphia, and Tampa police departments are set forth in the Appendix pages 100, 201, and 242, respectively.

Recommendation 3.6: The PPB should require its officers to record their use of force on a separate Use of Force Report. The PPB should use the information from these reports to analyze and manage its officers' use of force. The PPB should also log and track information from such reports in its early warning system.

III. Recommendations

Recommendation 3.1: The PPB should add a preamble or mission statement to its written deadly force policy, underscoring the Bureau's reverence for the value of human life and its view that deadly force is to be used only where no other alternatives are reasonably available.

Recommendation 3.2: The PPB should expand its written deadly force policy to provide that certain uses of force, such as strikes to the head or other vital areas with impact weapons, may not be used unless the officer is justified in using deadly force.

Recommendation 3.3: The PPB should revise its deadly force policy to prohibit officers from using deadly force to stop a fleeing felony suspect unless they have probable cause to believe that the suspect (1) has committed an offense involving the actual or threatened infliction or threat of serious physical injury or death, and (2) is likely to endanger human life or cause serious injury to another unless apprehended without delay. In addition, the policy should make clear that even in those circumstances, deadly force should not be used where (1) other means of apprehension are reasonably available to the officers, or (2) it would endanger the lives of innocent bystanders.

Department and Department of Justice, ¶ 53.

Recommendation 3.4: The PPB should consider whether it would be appropriate to revise its written deadly force policy to expressly require officers to refrain from taking actions that unnecessarily lead to the use of deadly force.

Recommendation 3.5: The PPB should revise its deadly force policy to clearly articulate when officers may draw or point their firearms and when they should re-holster them. In addition, the PPB should require officers to report in writing each instance in which they draw and point a firearm at another.

Recommendation 3.6: The PPB should require its officers to record their use of force on a separate Use of Force Report. The PPB should use the information from these reports to analyze and manage its officers' use of force. The PPB should also log and track information from such reports in its early warning system.

4. Investigation Procedures

Introduction

The importance of conducting thorough, impartial investigations of officer-involved shootings and in-custody deaths is difficult to overstate. In discussing investigations of officer-involved shootings, the International Association of Chiefs of Police (IACP) observed:

> [A] law enforcement agency's reputation within the community and the credibility of its personnel are . . . largely dependent upon the degree of professionalism and impartiality that the agency can bring to such investigations. Superficial or cursory investigations of officer-involved shootings in general and particularly in instances where citizens are wounded or killed can have a devastating impact on the professional integrity and credibility of an entire law enforcement agency.[60]

In short, an agency must rigorously investigate the conduct of its officers and do so without even the appearance of impropriety. One of the principal aims of our review is to assess whether the PPB met these challenges for the time period we examined (1997 to mid-2000) and whether the PPB is equipped to do so in the future. In this chapter, we discuss the PPB's investigation policies and procedures, both then and now. In the next chapter, we turn to the 34 investigative files we reviewed and discuss whether, and to what extent, PPB investigators carried out their duties with the necessary professionalism and impartiality.

[60] IACP National Law Enforcement Policy Center, *Investigation of Officer Involved Shootings: Concepts and Issues Paper* (August 1999).

Examining the PPB's investigative policies and procedures, most of which are embodied in PPB Manual Section 1010.10, the Bureau's deadly force policy, we found a number of problems, including:

- The PPB relies exclusively upon Homicide[61] investigators to investigate deadly force and in-custody death incidents, even though the policy and training aspects of such cases lie outside Homicide's area of expertise. Most major law enforcement agencies have abandoned or eschewed the Homicide-only model for models that include additional investigators specially qualified to examine the policy and training aspects of these critical incidents.

- Unlike many other agencies, the PPB did not appear to actively and consistently seek contemporaneous interviews of officers involved in officer-involved shooting and in-custody death incidents. For the time period we studied, involved officers[62] typically were not interviewed until at least three days after the incident — thereby increasing the risk of deliberate or inadvertent witness contamination.

- The PPB's rules regarding sequestration of involved officers and witnesses officers need strengthening.

- The PPB's rules do not adequately regulate the Traumatic Incident Committee, a group of volunteer officers who roll out to the scene of most officer-involved shootings.

- The PPB's deadly force policy does not contain sufficient safeguards to ensure that the statements of witness officers and civilians are memorialized accurately.

[61] The Homicide detail of the Detective Division handles virtually all investigations of officer-involved shootings and in-custody deaths. We will refer to the detail simply as "Homicide."

[62] Under PPB Manual, § 1010.10, an "involved" officer is one who has used deadly force.

- The PPB has a highly unusual policy requiring investigators to engage in an interviewing technique, known as "pre-interviewing," that has been prohibited by other agencies.

In addition, we also found a number of promising policies which could serve as a model for other law enforcement agencies:

- Since 1998, detectives from nearby law enforcement agencies have generally assisted the PPB in its investigation of officer-involved shooting cases. The PPB's willingness to open some of its most sensitive cases to scrutiny by neighboring agencies is both laudable and rare.

- In 1988, Homicide developed an interview checklist so that investigators do not overlook key lines of inquiry, such as an officer's training history and various tactical issues. The PPB should be commended for taking this step because most major law enforcement agencies do not provide their investigators with any written guidelines. With minor modifications, the PPB's interview checklist could stand as a model to other agencies.

- The Traumatic Incident Committee provides officers involved in shootings with an additional, peer-based level of psychological assistance. With some minor modifications, TIC could likewise serve as a model for other agencies.

I. The PPB Investigative Process

Like most major law enforcement agencies in the country, the PPB asserts that it investigates officer-involved shootings and in-custody deaths from three different perspectives: (1) criminal — whether the involved parties (police and civilian) should be charged with a crime; (2) administrative — whether the involved officers violated the agency's rules and regulations and therefore should be subject to discipline; and

(3) tactical — whether the involved officers followed their training and performed in a tactically sound manner.

We found significant disagreement within the Bureau on this point. Several experienced PPB detectives, who have handled many officer-involved shooting investigations, adamantly insisted that they were tasked *exclusively* with investigating whether officers involved in shooting incidents were guilty of a crime. That there was such disagreement on the scope of investigators' responsibilities in officer-involved shooting and in-custody death cases supports the need for the changes we recommend later in this chapter as to how the administrative and tactical perspectives should be investigated.

In the PPB, the Homicide detail of the Detective Division investigates all in-custody deaths and virtually all officer-involved shootings. Specifically, Homicide "rolls out" immediately to the scene of all cases where (1) an officer intentionally fires a gun at another person, (2) an officer accidentally fires his gun, resulting in injury, or (3) a person dies within PPB custody. Homicide is responsible for all aspects of the ensuing investigation, setting up the crime scene perimeter, directing criminalists to take physical evidence, and interviewing all involved parties and witnesses. Homicide is required to present the evidence in a neutral manner; investigators are not permitted to express their opinions or conclusions regarding the case. The documentary evidence is presented in an official investigative file comprising investigator memoranda, interview transcripts, autopsy or medical reports, video- or audiotapes, and the like. Physical evidence taken from the scene (*e.g.*, shell casings, blood swabs, and the like) is secured by the PPB's Identification Division and stored by the Property and Evidence Division.

Immediately upon completing the investigative file, Homicide routes a copy of the file to the Multnomah County District Attorney's (DA's) office for decision on whether to prosecute. Neither Homicide nor anyone else in the PPB makes a recommendation to the DA regarding whether to prosecute. As a matter of office policy, the DA presents all cases involving fatalities caused by police use of deadly force to the

grand jury and decides how to handle all other matters on a case-by-case basis. The criminal evaluation stage of the process is relatively brief. In most instances, the DA or the grand jury decide whether a case should be prosecuted within a month of the incident (often sooner) — a pace that outstrips that of many other jurisdictions, where the prosecution decision-making process can take well over six months. For the past 34 years, no officer in Portland has been indicted for an officer-involved shooting or in-custody death case.[63]

Once it has been determined that a PPB officer is not subject to criminal prosecution, a copy of the Homicide case file is routed to the unit commander of the involved officer(s) for review. The commander is required to prepare a written analysis of the incident and forward it to his or her Assistant Chief for review and comment. In addition, the Homicide case file and the unit commander's written assessment are provided to the PPB Review Level Committee, consisting of Bureau executives, for evaluation of the officer's conduct from a policy, tactical, and training perspective. There is no official timetable for conducting this review; files we reviewed indicated that the process generally takes several months. Upon receiving Homicide's report, the unit commander or the Review Level Committee can ask Homicide to conduct additional investigation. However, none of the 34 cases we reviewed was sent for additional investigation. The PPB reports that supplemental investigations do occur, albeit rarely.

It is in this context that we begin a detailed examination of the PPB's procedures.

[63] According to the PPB, the last indictment for an officer-involved shooting came in 1969, when a PPB officer, while on duty, shot and killed the husband of a woman he had been dating. The officer pled guilty to manslaughter charges.

By mentioning the lack of prosecutions we do not mean to offer views on the integrity of the criminal referral and evaluation process or an assessment that any of the 34 cases we reviewed should have resulted in criminal prosecution. Such assessments are outside the scope of our engagement and we did not undertake such an analysis.

II. Evaluation of PPB Policies and Practices

A. PPB Investigative Framework

1. Officer-Involved Shootings and In-Custody Deaths

As noted earlier, only Homicide investigates deadly force and in-custody death cases. PPB Manual Section 1010.10[64] provides the Detective Division with the exclusive authority to investigate officer-involved shootings[65] and in-custody deaths. As a matter of practice, the Detective Division assigns shooting and in-custody death cases to its Homicide detail. Homicide typically assigns a sergeant to be in charge of a team of at least four detectives. When notified of an officer-involved shooting or in-custody death incident, the Sergeant notifies his or her investigative team and they all roll out to the scene.

In addition, since late 1998, Homicide investigators are generally joined on the investigative team by two or more non-PPB detectives from the East County Major Crimes Team (a multi-jurisdictional task force comprising detectives from the PPB, the Multnomah County Sheriff's Department, the Gresham Police Department, and the Oregon State Police) to participate in the investigation. Specifically, the Major Crimes Team assists in investigating all shootings where someone is hit by a bullet and may be summoned to assist in complex shootings where no one is hit. The PPB's willingness to open some of its most sensitive investigations to outside police departments is both laudable and extremely rare among U.S. police agencies.

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[64] Section 1010.10 was substantially revised, effective May 10, 1998. Thus, some of the cases we reviewed fell under the "old" version and some under the "new." Unless indicated otherwise, our reference to various provisions of § 1010.10 will refer to language appearing in the current version.

[65] The exception to this rule is that firearms discharges at animals and accidental discharges which do not result in injury are investigated by the officer's own chain of command which may, in its discretion, hand the investigation over to Homicide. PPB Manual, § 1010.10 at 407 (2002).

In contrast, the PPB's Homicide-only model for investigating officer-involved shooting and in-custody death cases is not consistent with best practice. Over the past two decades, numerous agencies — including those in New York City, Los Angeles, Chicago, Philadelphia, Washington D.C., Boston, Miami, San Jose, Dallas, Houston, Phoenix, Denver, Cincinnati, and Memphis[66] — have stopped using the Homicide-only model. The prevailing view is that while Homicide investigators are typically well-qualified to conduct a *criminal* investigation, they lack either the training or perspective necessary to investigate officer-involved shooting or in-custody death cases from an *administrative* and *tactical* point of view.

Jurisdictions which have moved away from the Homicide-only model have instead adopted one of two different models. The first, which we will refer to as the Internal Affairs Overlay Model, leaves Homicide responsible for controlling the crime scene, conducting the criminal investigation, and taking voluntary statements from the involved officers. At the same time, however, Internal Affairs (IA) investigators conduct the administrative investigation, reviewing the crime scene and participating in Homicide's interviews of civilian and officer witnesses. (They do not, however, participate in Homicide's interview of the involved officers in order to avoid any appearance of coercion that might render the officers' statements inadmissible in a criminal proceeding.)[67] The IA investigators also receive all of Homicide's investigatory materials, including tapes and transcripts of interviews.

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[66] Two other exceptions to this trend are Seattle and Pittsburgh, which continue to leave officer-involved shooting and in-custody death cases solely to Homicide or the equivalent. Although we have not had the opportunity to assess the quality of Seattle's or Pittsburgh's deadly force and in-custody death investigations, we are persuaded that a broader, multidisciplinary approach constitutes best practice.

[67] This practice stems from the United States Supreme Court ruling in *Garrity v. New Jersey*, 385 U.S. 493 (1967). *Garrity* involved criminal charges against police officers for fixing tickets. During the pre-indictment investigation, the defendants were required to answer questions or be subject to termination. The Supreme Court held that, because the officers' choice was between self-incrimination or job forfeiture, the procedure was coercive, and thus the compelled statements could not be used in a criminal prosecution against the officers.

Prior to compelling a PPB officer to answer questions, Homicide provides the officer with a "Garrity Warning" form, which advises the officer that the questioning is intended solely for internal administrative purposes and the information gained from the interview cannot be used against the employee in a criminal proceeding.

In many instances, after receiving notification from the prosecutor that the involved officers will not be prosecuted, the IA investigators order the officers to submit to a second interview, conducted by IA alone, in which investigators attempt to fill in any gaps left in the Homicide interview, to address any inconsistencies in the evidence, and to ask additional questions relevant to policy and training issues. IA then prepares a summary report that, along with its underlying file, is presented to managers and executives for review.

Agencies following the IA Overlay Model include the Los Angeles County Sheriff's Department (LASD), the Miami-Dade Police Department, the San Jose Police Department, and Phoenix Police Department. The LASD's variation of this model, known as the LTD (Leadership and Training Division) Response Team, in many respects represents best practice in the area. The LTD Response Team is made up of (1) three investigators from IA, (2) two representatives from the Training Bureau (one from Force Training and one from Firearms Training), and (3) one or more additional specialists from Traffic Services, Custody Training, or other units whose expertise is relevant to the incident at hand.

For example, an LTD Response Team rolling out to the scene of an officer-involved shooting at the conclusion of a high-speed vehicle pursuit, a foot pursuit through backyards, and a search by police dogs might contain the following members: (1) three IA investigators tasked to put the case together; (2) two training representatives (one to evaluate the actual shooting and the other to evaluate tactics leading up the shooting, such as the foot pursuit); (3) a representative from the Traffic Bureau to assess the vehicle pursuit; (4) a representative from the Special Enforcement Bureau to assess the use of the police dog; and (5) a representative from the Risk Management Unit to evaluate the county's potential civil liability. Each of these different perspectives is included within the LTD Response Team's final report.[68]

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[68] LASD policies relating to the LTD Response Team are set forth in the Appendix, pages 91-99.

In addition, in 2001, the LASD, in response to public concerns about police investigations arising out of the Rampart scandal involving the neighboring LAPD, proposed to the Los Angeles County Board of Supervisors the creation of an independent civilian review agency, known as the Office of Independent Review (OIR) to oversee the LASD's IA investigations. In a number of respects, OIR functions similarly to the Independent Police Review (IPR) Division of the Portland City Auditor's Office. However, unlike IPR, OIR also monitors, and makes recommendations concerning, the progress of officer-involved shootings and in-custody death investigations. Whenever the LTD Response Team rolls out to investigate an officer-involved shooting or in-custody death case, at least one representative of OIR also rolls out to the scene to monitor the Team's investigation. OIR is not empowered to conduct an investigation of its own, but instead may make recommendations to investigators to improve the quality or broaden the scope of the ongoing investigation. Because OIR's recommendations are provided in "real time," *i.e.,* as soon as an issue surfaces, the LASD is able to take corrective action before serious problems arise or before potential evidence or witnesses become unavailable. Thus far, it appears that OIR's involvement has resulted in a noticeable improvement in the quality of investigations.[69]

Other police agencies have removed Homicide from officer-involved shooting and in-custody death cases altogether. They have embraced what we call the Specialist Team Model, in which a stand-alone group of specialists investigates all aspects of officer-involved shootings and in-custody deaths. Unlike Homicide and regular Internal Affairs investigators, these special investigators typically do not have a competing caseload of "regular" cases to occupy their time. In most versions of this model, the

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[69] Improvements effectuated by OIR include (1) more thorough collection of physical evidence before the crime scene is released, (2) more thorough questioning of witnesses during initial interviews, and (3) a broader focus on officers' conduct prior to the use of deadly force. OIR's initial success stems in large part from that fact that the office has received sufficient funding to ensure meaningful review. OIR has a staff of six full-time attorneys with extensive backgrounds in civil rights and criminal law issues, led by the former Chief of the Civil Rights Section of the U.S. Attorney's Office for the Central District of California. In addition, OIR has well-qualified support staff and other resources deemed necessary to fulfill its function.

investigators focus exclusively on officer-involved shootings and in-custody deaths; in some variations of this model, the specialists also investigate other high-risk uses of force.

The better Specialist Team systems, such as the one recently overhauled by the Metropolitan Police Department in Washington, D.C., are notable for providing the team members with advanced tactical and investigative skills training tailored for assessing officer performance in high-risk situations. This training is designed to improve investigators' ability to spot issues at the very outset of an incident so that they can be fully investigated. Membership in the group is typically highly competitive; only officers with exemplary records and skills are invited.

The Metropolitan Police Department system, known as the Force Investigation Team (FIT or FIT Team) is one notable example of best practice in the area. FIT has been in existence since 1999, although it was significantly improved in 2001 pursuant to a settlement agreement with the Department of Justice. Each FIT Team comprises at least four officers: two on-call investigators, one lead investigator, and one FIT manager. In addition, there are two types of investigative teams. One group, known as FIT-1, investigates: (1) all firearm discharges (except range and training incidents and discharges at animals); (2) uses of force resulting in death; (3) in-custody deaths; and (4) officer suicides with a service weapon. The second group, known as FIT-2, investigates: (1) uses of force resulting in a broken bone; (2) injuries requiring hospital admittance as a result of police use of force; (3) head strikes with impact weapons; (4) uses of force resulting in a loss of consciousness, risk of death, serious disfigurement, or disability or impairment of the functioning of any body part or organ; (5) bites from a department canine; and (6) referrals from the civilian Office of Citizen Complaint Review that involve allegations of high-risk force.

Particularly compelling about the FIT system is its intense focus on issues of policy, tactics, and training. While FIT's initial responsibility is to conduct a criminal investigation, an equally important duty is to assess whether officers could have safely

approached the situation in a manner less likely to lead to the use of deadly or significant force. To this end, FIT not only collects the evidence, but provides executives with a detailed analysis of the evidence and officers' conduct.[70] As FIT's Operations Manual puts it:

> [FIT's] final investigative report will include a description of the force incident and any other uses of force identified during the course of the investigation; a summary and analysis of all relevant evidence gathered during the investigation, and proposed findings and analysis supporting those findings. The proposed findings shall include:
>
> - A determination of whether the force was consistent with MPD policy and training;
> - A determination of whether proper tactics were employed;
> - *A determination whether lesser force alternatives were reasonably available.*[71]

The highlighted text is particularly noteworthy. In many agencies, including the PPB, the investigators' primary task is to collect evidence sufficient for an

Advanced Training for FIT Investigators

Washington D.C.'s FIT Team is a national model for many reasons, including the fact that investigators receive regular advance training to increase the quality of their investigations. For example, FIT's Operations Manual states:

> As scrutiny of various departments force incidents have shown, it is imperative that the Metropolitan Police Department constantly upgrade its ability to manage and understand these complex situations.
>
> The Force Investigation Team will always seek to enhance its operations through training, research, and development. Members will constantly strive to improve their ability to comprehend and investigate use of force scenarios. The sophistication of these investigations and the complexity surrounding related processes require training and education at unprecedented levels. The Force Investigation Team must become a "learning organization."
>
> Accordingly, it is expected that the department will support, and team members will engage in, constant and earnest education and learning. Methods will include but are not limited to:
>
> • Seminars and Training Sessions.
> • Familiarity of current events though various print, electronic, and Internet outlets.
> • Examination of police-industry publications, periodicals, and Internet sites.
> • Benchmarking with other law enforcement agencies.
> • Interagency coordination and collaboration.
> • Interaction with established law enforcement research and development organizations.
> • Consultation with educational institutions and industry experts.
> • Knowledge of CALEA standards.
> • Understanding of legal rulings and labor decisions.

FIT Operations Manual at 29 (2001).

[70] FIT completes its administrative investigation and tactical/policy review once it learns that the officer is not subject to prosecution.

[71] FIT Operations Manual at 14, ¶ 17 (2001) (emphasis added).

assessment of whether the involved officers' use of force was lawful and reasonable. FIT goes beyond that question and asks: could the involved officers, consistent with officer and public safety, have used less force?

Recommendation 4.1: The PPB should replace its Homicide-only investigative model with one that takes a multidisciplinary approach to deadly force and in-custody death cases. We believe either the IA Overlay model as enhanced by the LASD, or the enhanced Specialist Team model used in Washington, D.C., would work well in Portland.

2. Animal Shootings and Non-Injury Accidental Discharges

Animal shootings and non-injury accidental discharges are outside the scope of our engagement, and accordingly we did not review any investigations regarding these incidents. Nonetheless, it is worth noting that Portland's policy of assigning such cases to the concerned officer's chain of command falls within acceptable police standards. Best practice would require only two minor changes.

Recommendation 4.2: First, supervisors arriving at the scene of an animal shooting or non-injury accidental discharge should immediately notify the PPB's deadly force investigation unit, which would then decide whether to roll out to the scene and assume control of the investigation. Second, for those cases in which the shooting investigation unit declines to roll out, the unit should nonetheless review for completeness and objectivity the investigative file complied by the concerned officer's supervisor, with the option of taking over the investigation or remanding the file back to the supervisor for additional investigation or clarification.

B. Investigation Policies and Practices

Its Homicide-only investigative model aside, most of the PPB's procedures regarding officer-involved shooting and in-custody death investigations are sound and

well within the mainstream. We did, however, find a number of policies and procedures that are problematic and a number that, with minor modifications, could serve as models for other police agencies. We address these policies and procedures below.

1. Delay in Interviewing Officers

Among experienced police officers, it is beyond dispute that witnesses should be interviewed as soon as possible. Best practice likewise dictates that officers involved in a shooting or in-custody death incident be interviewed no later than several hours after the incident. Contemporaneous interviews enhance the integrity of the process by reducing the likelihood that the officers' account of events will be deliberately contaminated (*e.g.*, by efforts to "get officers' stories straight") or accidentally contaminated (*i.e.*, where an officer's memory of the incident is subconsciously affected by what he or she hears from others).

This issue is not addressed in any of the PPB's policies. Although the PPB's deadly force policy (Manual Section 1010.10) sets forth in great detail the various duties of Homicide investigators, there is no rule requiring Homicide investigators to request during the rollout investigation that a full interview[72] with the involved officer take place shortly after the investigation at the scene has been concluded. In addition, there is no rule requiring Homicide investigators to document their efforts to obtain such interviews in the case file.

In virtually all of the 34 cases we reviewed Homicide did not obtain a contemporaneous interview with an involved officer.[73] Instead, Homicide typically did

[72] By "full interview" we refer to the comprehensive, tape-recorded interview required by the PPB's deadly force policy. *See* PPB Manual, § 1010.10 at 406. There were several instances in which Homicide officials did ask questions of involved officers immediately after an incident, but these interviews were not tape-recorded and were not designed to cover all issues. For example, Homicide investigators briefly interviewed one officer so that they could obtain information about the location of a still-barricaded suspect.

[73] One exception involved an officer scheduled to start his vacation a few hours after a shooting incident.

not (and still does not) interview involved officers until at least three days after the incident. Because investigators do not document their interview requests, we could not determine from the files alone who was responsible for the delay. Our interviews of PPB officials, however, suggest that in some of the cases, the delay was due to the actions (or perhaps inaction) of Homicide investigators. For example, some PPB officials (including current and former Homicide investigators) erroneously believed that there was a policy or union agreement requiring Homicide to wait three days before interviewing involved officers. The officials frequently referred to this alleged policy or agreement as the "three-day rule." Thus, it appears that at least in some of the cases, the investigators may have not sought an interview in the hours after a shooting because they mistakenly believed they were not entitled to it.

Some we interviewed (including some current and former Homicide investigators) defended the three-day waiting period as reasonable, and even preferable to interviewing the officer shortly after the incident. These advocates typically argued that the delay was desirable because shooting and in-custody death cases are highly traumatic to the involved officers. Thus, they explained, it was unfair for the officer to be questioned so soon after the incident. In addition, some asserted that the three-day waiting period actually produced more reliable accounts, because the officers were given time to "decompress" and get their thoughts in order.[74]

These arguments are not persuasive. Police officers should be treated in the same fashion as similarly-traumatized civilians, such as those who have been the victims of violent crime. As a general rule, Homicide investigators interview civilians involved in, or witnessing, a shooting or in-custody death incident as soon as possible, regardless of their emotional state. Often, these civilians are taken from the scene of an incident to PPB headquarters and persuaded to stay — often for many hours — until Homicide has an opportunity to fully interview them.

[74] This was the view of some, but not all Homicide investigators. Other investigators adamantly maintained that delaying the interview of involved or witness officers was unnecessary and highly undesirable.

Second, there is no empirical support for the view that interviewing a witness within hours of a high-stress event necessarily produces unreliable testimony.[75] Indeed, the PPB does not consider its immediate interviews of crime victims to be inherently unreliable.

These issues may be illustrated by an example from one of the 34 cases we reviewed. At around 3:30 in the morning, a man at a bus stop pulled a knife and threatened to kill a woman sitting on the shelter bench. A PPB training officer and his trainee arrived at the scene and drew their guns on the suspect, who held his knife only inches away from the terrified woman. After some tense moments, the man turned away from the woman and began slowly advancing on the training officer, who was standing around 20 feet away. The officer shot the suspect twice. While Homicide investigators interviewed the highly traumatized victim within two hours, it appears that they did not make any attempt to interview the involved officer. The transcript from the victim's interview indicated that she was very shaken by the incident. Moreover, she told investigators that she suffered from schizophrenia and thus her memory was not very good. Nonetheless, Homicide pressed on with the interview. The involved training officer, on the other hand, did not give a statement until two and one-half days later.

The third problem with delaying interviews is that it increases the possibility of officer collusion or inadvertent contamination of witness memory. Once the involved officers leave the crime scene, there is no one to prevent them from "getting their stories straight." In addition, an officer's recollection may be tainted, subconsciously or otherwise, by something read or heard during the waiting period.

It is also worth noting that the apparent reluctance of some investigators even to *ask* involved officers for a contemporaneous interview is a feature we have not seen in

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[75] We recognize that there is significant research indicating that officers' perceptions can be distorted during and after a traumatic event such as a deadly force incident (*e.g.*, "tunnel vision," auditory exclusion). However, waiting to interview the officer will not affect these phenomena (*i.e.,* there is no indication that additional time will "restore" the officer's perceptions).

any other major law enforcement agencies.[76] Investigators at other police agencies take the view that officers should be interviewed as soon as possible so as to obtain an uncontaminated, unfiltered account of the incident. Although the decision to submit to a voluntary interview rests with the involved officer, a number of agencies have worked hard to build a level of trust sufficient to persuade officers to give same-day interviews. Some agencies, such as the Los Angeles County Sheriff's Department, and the San Jose, Phoenix, Tampa, and Miami-Dade police departments, have generally succeeded in this effort.

It is also important to note that there are many within the PPB who share our view that investigators should seek to obtain contemporaneous interviews of involved officers. The Commander of the Detective Division, for instance, has recently tried to persuade the officers' unions to discuss shortening, if not eliminating, the *de facto* waiting period that currently exists.

The Phoenix Police Department has taken a different approach that warrants further study by the PPB. In that department, Homicide investigators rolling out to the scene of a deadly force or in-custody death incident promptly ask all involved and witness officers to submit to voluntary, tape-recorded interviews. Two thirds of the time, the officers agree. In addition, all of the officers — regardless of whether they provided a statement to Homicide — are ordered to submit to a full, tape-recorded interview by Internal Affairs[77] investigators before being relieved from their work shift. Because compelled statements (and their fruits) are inadmissible in criminal proceedings against the officer (*see* note 67, above), IA does not share these taped statements (or their fruits) with the criminal investigators (Homicide) or the District Attorney's office. Instead, the officer's compelled interview with IA is used exclusively for the Department's administrative and tactical review. In this manner, Phoenix has been able to obtain

[76] Because we have not conducted an exhaustive national survey, we cannot say that PPB is the only major agency exhibiting this reluctance to interview officers promptly after an officer-involved shooting or in-custody death incident. We have, however, found no other such agency.

[77] Phoenix's IA unit is formally known as the Professional Standards Bureau.

contemporaneous interviews of officers in 100 percent of its cases. The current head investigator for Phoenix's Internal Affairs unit reports that this approach has worked without problems for the roughly 120 officer-involved shooting cases he has investigated over the past five years.

Recommendation 4.3: The Bureau should revise its policies to make clear that investigators should *always* strive to obtain a contemporaneous, tape-recorded interview of involved officers. Such a policy would not only ease doubts about officer collusion, but place officers and civilians on the same footing. In addition, in those cases where an officer declines to provide a contemporaneous interview, investigators should be required to thoroughly document their efforts to obtain the interview, including (1) when the request was made, (2) to whom it was directed, and (3) the reason(s) for the declination.

Recommendation 4.4: The PPB should meet with the leadership of the police unions to work out procedures for taking voluntary statements from involved officers in the hours immediately following a shooting or in-custody death incident. Interviews would not be conducted until after the officers have been given an opportunity to consult with a lawyer and/or union representative.[78] The unions should encourage involved officers to provide investigators with contemporaneous statements, and likewise should encourage the lawyers they furnish to their members to facilitate such prompt statements.

Recommendation 4.5: The PPB should study the Phoenix system of obtaining contemporaneous statements, in which all involved or witness officers are ordered to speak to Internal Affairs investigators no later than a few hours after the deadly force or in-custody death incident, regardless of whether they agreed to provide a separate, voluntary statement to Homicide investigators.[79]

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[78] Experience with other agencies has shown that contemporaneous interviews do not undercut officers' legal right to confer with a union representative or legal counsel.

[79] While the PPB may not wish to adopt a blanket policy as Phoenix has done, it may benefit by learning how Phoenix has been able to obtain contemporaneous interviews for all shooting and in-custody death cases without jeopardizing the District Attorney's ability to prosecute appropriate cases.

2. Officer Sequestration Rules

The problems created by the three-day (or longer) delay in obtaining involved officer interviews are compounded by the fact that PPB policy has not provided sufficient precautions to prevent officers from discussing the incident among themselves prior to giving a tape-recorded statement to investigators. Moreover, the PPB has no policy to address this risk for cases in which a suspect dies in custody without the use of deadly force.

Rules for Deadly Force Investigations. The rules governing the aftermath of deadly force incidents are set forth in PPB Manual Section 1010.10. The issue of group discussion of a deadly force incident is addressed, albeit briefly. The version in effect from January 1, 1997, to May 9, 1998, stated:

> [M]embers [using deadly force] will avoid extensive discussion of the incident with anyone involved in the incident prior to being interviewed by the detectives or supervisor.[80]

Effective May 10, 1998, the policy was slightly modified to note that officers would be permitted to speak to union representatives and legal counsel:

> The [involved] member will be provided the time to discuss the incident with his/her immediate supervisor and/or RU [responsible unit, *e.g.*, precinct] manager, union representative, and private attorney. The member will avoid *extensive* discussion of the incident with anyone involved in the incident prior to being interviewed by a detective or supervisor.[81]

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[80] General Order 1010.10 at 4, ¶ 2 (September 13, 1993).

[81] PPB Manual Section 1010.10 at 406, ¶ 4 (2002) (emphasis added).

This latter version remains in effect today.

The current version of Section 1010.10 also contains a similar provision relating to witness officers:

> Prior to the interview [which the preceding paragraph limits to interviews that occur during the shift in which the incident occurs] and walk-through with the detective witness members will not have *extensive* discussion about the incident with any other person, except their immediate on-scene supervisor and their union representatives.[82]

Both the current and prior versions of the involved officer rule are problematic because they fail to prohibit *all* discussion of the incident by involved and witness officers prior to being interviewed by investigators. Instead, both versions merely prohibit discussion that is "extensive." The rules are inadequate in several respects. First, the PPB does not (and in our view, cannot) provide officers with useful guidance on when a discussion of a deadly force incident becomes "extensive" and therefore forbidden. Second, there is no rule (1) barring officers unconnected with the incident providing involved or witness officers with information that they might not otherwise possess,[83] or (2) requiring involved or witness officers to avoid exposure to sources of information about the incident (*e.g.,* press accounts or the Bureau grapevine) prior to submitting to a tape-recorded interview by investigators.[84] Finally, the policy errs in assuming that there can be no harm in allowing *some* discussion, so long as it is not "extensive." Officer collusion can occur without a great deal of discussion.

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[82] PPB Manual Section 1010.10 at 407, ¶ 4 (2002) (emphasis added).

[83] The risk of an involved officer unsolicited obtaining information from officers who are neither involved nor witnesses is not merely theoretical. One PPB officer we interviewed, who had been involved in a shooting, related how fellow officers from his precinct volunteered crucial information to him about the shooting before he was interviewed by Homicide.

[84] Such a rule is analogous to a court's directive that jurors avoid media coverage or other discussions of the case prior to the issuance of their verdict.

Another problem with both the prior and current versions of the policy is that the ban on extensive discussion is lifted once the involved officer has been interviewed by "a detective *or supervisor*" (emphasis added). If Homicide is in charge of conducting the investigation, an interview with a supervisor — which is not tape-recorded — should not be considered sufficient to preserve the officer's account. The better rule would be to prohibit all discussion among involved officers and witness officers until Homicide has concluded its investigation.

A related problem with the PPB's policy is that it fails to ensure that all involved officers and witnesses are physically separated from each other until they have given a taped statement to Homicide investigators. The version of Section 1010.10 that was effective between January 1997 and May 9, 1998, states:

> In situations requiring Detective Division involvement, the involved member(s) will not drive vehicles following the incident. A Bureau member will drive them to the Detective Division.[85]

This provision was plainly inadequate, because it did not require officers to be separated at the scene and did not provide that each officer would be driven back to Detectives in a separate vehicle. In addition, by merely requiring that the driver be a "Bureau member," the policy left open the possibility that the driver might have been a witness.

The May 10, 1998, amendment to the policy, which remains in effect today, cured some of these problems, but did not go far enough. The policy now provides that the driver must be an "uninvolved member." PPB Manual at 414, ¶ 6 (2002). The policy, however, does not contain a definition of "uninvolved member." Adding to the confusion is a definitional provision of Section 1010.10, at 405, indicating that an

[85] General Order 1010.10 at 4, ¶ 3 (September 13, 1993).

"involved member" is one who used deadly force. Thus, it would seem that those who did not use deadly force are "uninvolved members." The revised policy, therefore, may be read to allow witness officers to drive officers who used deadly force. The PPB should revise its policy to remove the ambiguity.

In addition, the 1998 revision failed to ensure that in each case, officers who participated in or witnessed a deadly force incident do not travel in the same vehicle. Instead, the revised policy states:

> Whenever practical each involved member and witness member should be transported in a separate vehicle.[86]

The phrase, "whenever practical" is an unnecessary loophole. Given the large number of units that respond to an officer-involved shooting, PPB should have the resources to keep officers separated until they have given a taped statement to investigators.

It is worthwhile noting that other agencies that had similarly lax rules regarding officer sequestration have changed their policies. For example, in 1992 the Kolts Commission criticized the policies of the Los Angeles County Sheriff's Department and the Department promptly changed its rules. In 1999 the Metropolitan Police Department in Washington, D.C. came under fire from the Justice Department for similar problems. The sequestration problem was rectified in the agency's settlement agreement with the Justice Department. More recently, the Los Angeles Police Department, whose sequestration rules were in some respects superior to the PPB's, was required to substantially tighten its policy pursuant to its 2001 consent decree with the Justice Department.

No Policy Concerning In-Custody Death Cases Not Involving the Use of Deadly Force. Another shortcoming in the PPB's policies regarding officer

[86] PPB Manual Section 1010.10 at 414, ¶ 6 (2002)

sequestration is that they apply only to deadly force cases. Thus, the PPB did not, and does not, have any rules governing officers' conduct in the aftermath of in-custody death cases that did not involve the use of deadly force. The PPB's revised rules regarding sequestration should extend to these cases as well.

Recommendations 4.6-4.9: The PPB should change its policies to minimize the risk of witness contamination and to enhance the integrity of the investigative process. In addition, the PPB's policies regarding officer discussion and sequestration apply only to cases where an officer has used deadly force. The PPB should expand the scope of Manual Section 1010.10 to include in-custody death cases that do not involve the use of deadly force.[87]

3. Traumatic Incident Committee (TIC) Members at the Scene

Although the PPB's deadly force policy discusses in great detail the obligations of supervisors and investigators who arrive at the scene, it says very little about a group of volunteer officers who roll out to the scene of every officer-involved shooting and who often have access to the crime scene and the involved officers well before Homicide. These officers belong to the Traumatic Incident Committee, also known as TIC or the TIC Team. TIC consists of PPB officers (1) who have been involved in a deadly force incident, or (2) have a spouse or domestic partner in the Bureau who was involved in an incident. TIC officers roll out to the scene of certain incidents, including officer-involved shootings (but not in-custody deaths), to provide emotional support and to explain to involved officers how the investigative process works. Although TIC is a volunteer organization, it operates under the aegis of the PPB's Employee Assistance Program (EAP).

Of concern here is the fact that PPB policy does not regulate the conduct of TIC at the scene of a shooting. This is a particular problem because, more often than not, TIC arrives at the scene before Homicide. Homicide investigators on occasion have arrived at

[87] The full text of these recommendations is set forth at the end of this chapter.

the scene to find TIC members standing in the middle of a crime scene containing as-yet undocumented evidence. The potential for crime scene contamination (intentional and inadvertent) is clear. Yet the PPB's policies do not bar TIC volunteers from the crime scene. In addition, TIC's handbook does not address the issue.

A second, related problem concerns TIC's ability to contaminate witness testimony by discussing the details of the incident with involved or witness officers. The previous version of the PPB's deadly force policy, which was in effect for a portion of our review period (between January 1, 1997 and May 9, 1998), expressly contemplated that officers would discuss the incident with TIC before speaking to Homicide:

> During the investigation, the member(s) will be provided the time to discuss the incident with their immediate supervisors(s) or Commander, Chaplain, TIC Team members, union representatives, and a private attorney. The member(s) will then be asked to discuss the incident with detectives.[88]

This policy was inappropriate. The purpose of TIC is not to go through the details of the incident, but to provide the officer with emotional support and basic information regarding the investigation process.

This policy was revised effective May 10, 1998. The revised (and still current policy) removes any reference to a TIC team member "discuss[ing] the incident" with involved officers. Instead, the policy states that TIC "will also discuss with the member involved any professional assistance and counseling that is available." Manual § 1010.10, at 411. While this revision is a substantial improvement, it falls short by failing to specifically prohibit TIC from discussing the incident with the officers. Although we did not find any evidence of collusion or inadvertent witness contamination through such on-

[88] General Order 1010.10 at 4, ¶ 4 (September 13, 1993).

scene communications, such conduct might not be documented in the normal course. Indeed, Homicide investigators never (1) interviewed TIC Team members to ascertain if any such discussions took place, or (2) asked involved or witness officers to disclose the substance of their conversations with TIC volunteers.[89]

Recommendations 4.10-4.11: In order to minimize the risk of crime scene and witness contamination by TIC Team members, the PPB should issue detailed guidelines regarding TIC volunteers' presence at the scene of deadly force or in-custody death cases. Specifically, the PPB should clearly state that TIC Team members should not be permitted to access the crime scene without express authorization from investigators at the scene. In addition, the PPB should expressly forbid TIC Team members from discussing the underlying incident with involved or witness officers until the officers have completed a comprehensive tape-recorded interview with investigators. Because the TIC Team and EAP representatives we met with told us that they already avoid discussing the incident with involved officers, adopting these bright-line rules should accomplish the PPB's investigative objectives without impairing TIC's mission.

4. Untaped Interviews

All interviews with officers who are involved in or witnesses to a deadly force or in-custody death incident should be video- or tape-recorded. Recording each and every interview not only minimizes the risk of collusion (or that investigators will provide incomplete or careless summaries of witness statements), but also allows PPB managers and executives to observe firsthand how effectively and fairly investigators conduct their interviews.

The PPB already subscribes to this philosophy in its policy governing Internal Affairs investigations of personnel complaints. The PPB requires that IA investigators

[89] Potential inquiries of this sort may have been limited since the enactment of a 1999 law, Oregon Revised Statutes § 181.60, providing that statements between law enforcement officers and members of an employee assistance program "in a peer support counseling session" are confidential.

"[t]ape record all interviews of members and if possible of all non-Bureau complainants or witnesses" when investigating personnel complaints, including those involving relatively minor allegations. PPB Manual § 330.30(d), at 78 (2002). However, the PPB did not, and still does not, take this position with respect to Homicide's investigation of officer-involved shooting and in-custody death incidents. Instead, the PPB grants Homicide broad discretion to conduct untaped interviews and to accept witness officers' reports in lieu of any interview.

All Witness Interviews May Be Untaped. The PPB's previous and current deadly force policies appropriately state that if an officer who used deadly force agrees to submit to an interview, the interview should be tape-recorded.[90] However, neither version of the policy requires Homicide to tape-record interviews of officer and civilian witnesses.[91] Moreover, both versions of the policy allow Homicide investigators not to conduct *any* interviews of witness officers; instead, Homicide may simply ask the officers to prepare a written report.

A written report is a poor substitute for an interview, and an untaped interview is not as credible as a taped one. As we mentioned earlier, the PPB's policies regarding IA investigations of personnel complaints, which may involve much less serious matters, forbid such practices for precisely those reasons. It therefore seems appropriate for the PPB to adopt a similar policy regarding investigations of deadly force and in-custody death cases.

Perhaps due to these concerns, Homicide investigators in the cases we reviewed generally did tape their interviews of witness officers and at least some civilians who witnessed an officer-involved shooting or in-custody death incident.[92] Nonetheless, in

[90] *See* General Order 1010.10 at 4, ¶ 4 (September 13, 1993); PPB Manual § 1010.10 at 406, ¶ 7 (2002).

[91] *See* General Order 1010.10, at 4, ¶ 4 (September 13, 1993) ("All Bureau members considered to be witnesses shall submit to an interview or complete a written report."); Manual § 1010.10 at 407, ¶ (b)(3) ("All witness members will be required to submit to an interview and/or complete a written report, prior to going off shift.").

[92] In those cases where it chose not to tape witnesses, Homicide did not explain that decision.

certain circumstances, Homicide's decision not to tape its witness interviews can create the appearance of possible impropriety.

For instance, in one case we reviewed, Homicide investigators learned that three civilians had witnessed a confrontation that resulted in an officer-involved shooting. Although Homicide had tape-recorded an interview of a civilian who had been with the suspect earlier that evening, it did not tape its interviews with the three civilians who actually saw the events leading up to the shooting. The decision not to tape the interviews might appear to some as suspicious, particularly given that (1) Homicide's summaries of these untaped interviews contained officer-exonerating quotations attributed to the witnesses,[93] and (2) Homicide's records indicated that the civilians were cooperative and had agreed to make themselves available for follow-up questioning. In not recording these civilians' interviews in the first place, and in failing to call the civilians back for a tape-recorded interview, the investigators unnecessarily exposed the PPB to two risks: claims that the investigation was conducted in a biased manner, and the possibility that the civilians would later change their stories and dispute that they had made the statements attributed to them.

Over the past 20 years, agencies in most major jurisdictions, including New York, Chicago, Los Angeles, Washington, D.C., San Diego, and Phoenix, have revised their investigation policies to ensure that, whenever possible, all interviews of civilian witnesses are video- or tape-recorded. In so doing, these agencies have not only enhanced public confidence in the investigation process, but have protected themselves from the risk that witnesses will change their accounts if called to testify in a criminal or civil case.

Recommendation 4.12: The PPB should revise its policies to ensure that all officer witnesses submit to a taped interview and that all civilian witnesses are

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[93] One of the witnesses was quoted as saying, "I think the police did what they had to do. They had no choice." Another was quoted as saying, "Without a doubt the officers didn't have a choice. He [the suspect] got too close to the officers for their safety."

interviewed on tape whenever possible. Transcripts of all interviews should be included in the case file.

Recommendation 4.13: If a civilian witness refuses to be tape recorded or videotaped, then investigators should prepare a narrative of the statement to be signed by the witness.[94]

Scene Walk-throughs Are Untaped. Pursuant to PPB policy, Homicide investigators may ask an officer who was involved in or witnessed a deadly force or in-custody death incident to participate in a so-called "walk-through." "In a walk-through, a detective and the involved member(s) and/or witness member(s) walk through the scene of the incident to determine the positions of individuals, direction of fire, field of fire, number of shots fired, location of physical evidence and possible witnesses." Manual Section 1010.10 at 405, ¶ 5. Typically, but not always, Homicide investigators will look to a witness officer, rather than an involved officer, to participate in a walk-through. In all instances, the officer may be accompanied by legal counsel during the walk-through.

PPB practice has been not to videotape[95] or tape-record the walk-through and any concurrent discussions between the officer(s) and Homicide investigators. This leaves open the possibility that the walk-through process can be used to coach officers or inadvertently shape their testimony from the very outset of the investigative process. It also leaves open the possibility that the investigators will not accurately or completely summarize what was said at the scene.

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[94] We found no evidence in the 34 cases we reviewed that Homicide gave witnesses a copy of their interview summaries for review, correcting, or approval. Should the PPB fail to adopt our recommendation that all interviews be tape-recorded, it should revise its policies to ensure witnesses are given this opportunity. In this regard, the PPB may look to the highly-regarded FIT Team in Washington, D.C., which follows this practice regularly. *See, e.g.,* FIT Team Operations Manual at 14, ¶ 14 (2001) ("If a non-police officer witness refuses to be tape recorded or videotaped, then investigators shall prepare a written narrative of the statement to be signed by the witness").

[95] PPB criminalists videotape the crime scene both before and after it has been processed.

In interviews, some Homicide officials have asserted that it was unnecessary to record walk-throughs because the officers merely describe the location of evidence and bullet trajectories. The files we reviewed, however, made clear that this was not always the case. Many files contained Homicide summaries indicating that the officer(s) participating in a walk-through had provided a detailed narrative of the incident. Consider, for example, a Homicide investigator's summary of his walk-through with an officer who had fired his gun seven times at a suspect:

> I then began the walk through. Officer [A, who had used deadly force in the incident] escorted me to the location . . . . [He] told me that he and his partner Officer [B] were driving northbound . . . when they heard two or three gunshots . . . his attention was drawn to a black male wearing a white t-shirt type shirt . . . as the individual approached the corner . . . it was clear that he had a handgun in his right hand. Officer [A] stated that at this point . . . he was trying to put the vehicle in park and had his weapon in his off (left) hand. The subject "squared up on them" with the weapon and [Officer A] began firing his weapon at the subject. . . .

Clearly, the officer was doing far more than identifying the location of evidence, trajectories and the like. He was providing Homicide with a detailed narrative of the entire incident, including his explanation for using deadly force.

Recommendation 4.14: PPB investigators should seek to video- or audiotape all officer walk-throughs. If the interview is audio- rather than video-taped, all gestures and relevant physical actions by the officer doing the walk-through should be described on the tape. By taping all walk-throughs, subsequent reviewers (from the grand jury to PPB executives) will be able to assess the quality of the walk-through, including the quality of investigators' questions.[96] In addition, taping the walk-through will enable reviewers to

[96] As we discuss more fully in Chapter 5, we found some problems with the way Homicide interviewed PPB officers during their tape-recorded interviews. Taping the walk-through would enable supervisors to identify and address any similar problems that might occur during walk-throughs.

identify any inconsistencies between an officer's statement at the scene and his later, more detailed interview with Homicide. Transcripts of the officers' statements during the walk-through should be included in the case file.

"**Pre-Interviewing."** One of the practices we found of greatest concern is the PPB's policy of conducting untaped interviews of involved officers before turning on the tape recorder and taking a formal statement. This practice is known in law enforcement circles as "pre-interviewing."

Although we have seen other agencies engage in (and subsequently abandon) this practice,[97] the PPB is the only agency we have come across where pre-interviewing is *mandatory*. Specifically, Portland's Manual states: "After meeting with a private attorney, the [involved officer] will be asked to discuss the incident with the detective. Following the discussion, the member will be asked to submit to a tape-recorded interview." Manual, § 1010.10, at 406, ¶ (a)(7) (2002). The previous version of this policy, which was in effect until May 9, 1998, contained a similar requirement.[98] Although PPB policy does not require Homicide to conduct pre-interviews with civilian or officer witnesses, Homicide has extended the practice to them as well — a further compromise of investigation integrity.

Without a video or tape-recorder rolling during the pre-interview, there is no sure way to know what was said and, perhaps equally importantly, how it was said. Nor is there any sure way to know if the investigator has fairly and accurately summarized the interview. At the very least, the absence of a recording can give rise to an appearance of impropriety.

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[97] For example, the Los Angeles County Sheriff's Department abandoned pre-interviewing after the practice drew sharp criticism from the Kolts Commission. *See* Kolts Report at 152 ("The LASD Homicide Bureau should not permit untaped portions of interviews . . . ."). In addition, in March 2002 the Justice Department, in a technical assistance letter to the Detroit Police Department, criticized that agency's failure to tape record all witness and officer interviews in force and complaint investigations. *See* U.S. Department of Justice, Technical Assistance Letter: Detroit Police Department – Use of Force Investigations (March 2002).

[98] *See* General Order 1010.10, at 4, ¶ 4 (September 13, 1993).

In many of the cases we reviewed, pre-interviews lasted much longer, sometimes three or four times longer, than tape-recorded interviews. For example, in one case, a key involved officer was "pre-interviewed" off tape for more than two hours, while his tape-recorded statement lasted only 39 minutes. A second key officer was pre-interviewed, according to an investigator's note, for "well over an hour." However, her taped interview, including an introductory statement by investigators, took only 20 minutes.

In a handful of cases we reviewed, statements attributed to witnesses in untaped pre-interviews did not appear in the taped interview, thus highlighting the problems with untaped pre-interviews. Indeed, in some cases, the taped statement directly contradicted the investigators' summary of the untaped pre-interview. For example:

- In one case, a Homicide investigator conducted an untaped pre-interview of an officer who witnessed an officer-involved shooting. The investigators' summary of the pre-interview made clear that the officer first believed that the shooting was accidental: "I asked [the witness officer] what his initial thought was when he heard the shot being fired and *he thought it was an accidental discharge*." (Emphasis added.) The investigator's summary did not, however, state the officer's subsequent view or discuss how the officer came to change his views of the incident.

  More troublingly, during the taped interview of the officer immediately following the pre-interview, the Homicide investigator appeared to try and cover the same territory. When the officer avoided any mention of a suspected accidental discharge in his answer, the investigator moved on without ever exploring the subject of a possible accidental discharge or why the officer originally suspected one. Given how important it was to determine whether the PPB officer had

negligently fired his weapon, the investigators should have raised and fully explored the issue in this witness officer's taped interview.[99]

- In another case, a Homicide investigator conducted an untaped pre-interview of a civilian eyewitness. The investigator's summary of the pre-interview contained numerous quotations attributed to the civilian, all of which tended to exonerate PPB officers. One quotation reads, "The police officer had his arms raised and was defending himself" — thereby implying that the suspect was the aggressor in the struggle.[100] However, the civilian made no such claim during the tape-recorded interview. There he described the officer as the aggressor, placing his hands around the suspect's neck while the suspect tried to flee. Once again, the Homicide investigators did not seek to clear up the discrepancy.

In circumstances such as these, the apparent and unresolved discrepancies between the taped and untaped statements could lead some observers to conclude that the investigator was seeking to "protect" the involved officer.

Finally, it appears that Homicide's reliance upon leading questions in its taped interviews — a concern we address more fully in Chapter 5 — may stem in part from the pre-interview process. We found numerous instances in which Homicide investigators appeared to use leading questions to elicit statements previously made by witnesses during the pre-interview.

In one case, a Homicide investigator began the taped interview of an officer by stating, "[A]s you know we've been over this fairly exhaustively already, I'd like to just

[99] The investigators' failure to raise the possibility of an accidental discharge in the taped interview is particularly egregious given that another officer at the scene reported that the subject officer fired his weapon *after* the suspect had already dropped his own — testimony entirely consistent with an accidental discharge.

[100] Other exculpatory quotations attributed to the civilian in his pre-interview but not found in the tape recorded interview, include: "They took him down. . . . That's what they had to do! He was struggling to get away. They took him down. They were wrestling with him for a full minute. He [the suspect] was like superman! He was definitely resisting."

do it again for the tape . . . ." It should be noted, however, that neither the content nor the circumstances of this earlier, "exhaustive" interview are indicated in the case file. Later in the interview, the Homicide investigator appears to use information gleaned from the untaped pre-interview to correct some details in the officer's testimony because it evidently conflicted with his untaped pre-interview, as follows:

> Officer: . . . I got to the front yard I saw the suspect running east and north across…
>
> Investigator: You mean north and west."
>
> Officer: [T]hat's right, north and west…"

PPB officials uniformly acknowledged in their meetings with our staff that leading questions should be kept to a minimum. Eliminating the pre-interview will aid the Bureau in achieving that goal.

Some within the PPB defend the practice of pre-interviewing officers involved in officer-involved shooting or in-custody death incidents. They maintain that the pre-interviews serve to "break the ice" and calm the officers down, and that turning on a tape recorder at the outset would impede the investigation process because it would make officers nervous. We disagree. We have reviewed hundreds of taped officer interviews conducted by agencies that have either abandoned the practice of pre-interviewing or never followed the practice in the first place. We found that experienced investigators were quite capable of putting nervous officers or civilians at ease after they turned on the tape recorder. We have no reason to believe that the PPB's investigators are unable to follow their example.

Recommendation 4.15: The PPB should video- or audio-tape the entirety of all interviews with officers and civilians.

C. Promising Policies and Practices

As we mentioned at the outset of this chapter, we found a number of PPB policies and practices to be innovative and potential examples of best practices. We turn to them now and offer a few suggestions for improvement.

1. Interview Checklist

Although many law enforcement agencies perform good and even excellent deadly force and in-custody death investigations, few have taken steps to ensure that each investigation covers certain topics, regardless of the particular facts of the case. We have consistently recommended that agencies provide investigators with an interview outline or checklist containing critical questions or topics that should be addressed in every interview.

We thus find it exemplary that the PPB has been using an interview outline/checklist since 1988 — making it a pioneer in this area. A copy of the current interview checklist is set forth in the Appendix at page 27. It is worth noting that Homicide's interview checklist covers a number of critical matters that are often overlooked in other agencies' investigations of deadly force incidents. For example, few agencies regularly inquire into whether officers' decisions may have been affected by medication, alcohol, or lack of sleep (with the latter being a particularly significant risk factor, often due to overtime, off-duty hours worked, or night shift assignments). In addition, many agencies neglect to cover the officer's training or consideration of the force continuum prior to discharging a weapon. The PPB checklist serves to remind Homicide investigators not to overlook these important matters.

Notwithstanding its impressive virtues, the PPB's checklist could be better.

Recommendations 4.16-4.17: With a few relatively minor modifications, the PPB's interview checklist could serve as a national model. The PPB should make its checklist

more detailed, and should mandate that investigators cover every matter in the checklist in every interview. Additional areas of inquiry should include:

- Asking officers whether: (1) in hindsight, they could have approached the incident in a way that presented less risk to themselves and others; and (2) they have any suggestions for improving relevant PPB training.

- More detailed tactical inquiries, such as:

    - Identifying the moment officers decided to take any of the following actions, and the circumstances that led them to do so:
        - Draw their guns;
        - Pointing their weapons at a suspect or in the direction of a perceived threat; and
        - Any subsequent decision to lower or re-holster their weapons.
    - The grip and shooting stance the officer used, particularly if the officer was holding a flashlight;
    - Whether the shots were sighted (*i.e.*, whether the officer took aim using his gun sights);
    - Whether the officer took advantage of available cover and concealment;
    - Where the suspect was armed with a weapon other than a gun, officers at the scene should be asked to identify not only the distance between each officer and the suspect, but whether the officers had an opportunity to tactically retreat to a safer distance or take cover behind some barrier.

The above list is not intended to be exhaustive. Rather, it illustrates a variety of critical questions that frequently arise in an officer-involved shooting. We expect that members of the PPB Detective and Training divisions can draft a comprehensive list of questions that should customarily be covered.

Recommendation 4.18: The PPB should also prepare a similar outline for cases involving high-risk uses of force or in-custody deaths, as those cases present equally serious issues of policy, tactics, and training.

2. The TIC Team

Members of the public and even some within police agencies tend to overlook the important fact that, in most cases, officers who fire their weapons at suspects have undergone a near-death experience. Few have an imagination rich enough to truly understand what it is like to be face-to-face with someone who is trying to kill you. It is even more difficult to fully grasp the additional overlay of stress added by a subsequent deadly force investigation, in which numerous investigators and officials roll out to the scene. Even officers who acted irreproachably and heroically — and we certainly came across such officers in the files we reviewed — can suffer serious psychological and even physical setbacks.

In the past two decades, an increasing number of police agencies have taken measures to deal with officer stress. The PPB's creation of the Traumatic Incident Team (TIC) is one outstanding example of peer-based support systems that have emerged in recent years.[101]

As we mentioned earlier in this chapter, TIC is made up of volunteer PPB officers who have either undergone a deadly force incident themselves or are married to or partnered with PPB officers with that experience. The volunteers agree to a rotating on-call system in which a team of officers can respond to the scene of deadly force incidents. Upon arriving at the scene, TIC members provide the involved officers with emotional support and briefly outline how the investigative process works. They also discuss

[101] Other agencies with similar models include the Washington County (Oregon) Sheriff's Department (Stressful and Traumatic Incident Committee), the San Francisco Police Department (Stress Unit and Peer Counseling Program), the New York Police Department (Trauma Counseling and Response Program), the San Diego Police Department (peer support arm of the Medical Assistance Unit), and the Chicago Police Department (Traumatic Incident Debriefing Program).

emotional and physical symptoms that may accompany high-stress incidents and offer ideas on how to cope with them. The emphasis is upon assuring officers that their emotional reactions are not a sign of weakness, but part of the normal recovery process.

After an involved officer has been allowed to leave the scene of a shooting, TIC members follow-up a day or two later to ensure the officer does not feel isolated and to remind the officer to pay a visit to a psychologist before returning to work. These measures can be particularly helpful, and the TIC Team should be commended for taking them.

These measures were developed to assist officers in coping with the emotional after-effects of a deadly force incident. For example, in 1998 the PPB's deadly force policy was amended to provide that where deadly force results in injury or death, the officers who used or witnessed the incident are entitled to be excused from duty with pay for a minimum of three working days.[102] In addition, where deadly force does not result in injury or death, officers who used or witnessed the incident may be given an alternative assignment at the discretion of their commanding officers. Finally, the PPB requires involved officers in hit shootings to see a Bureau-approved psychologist before returning to duty, and reimburses officers for up to six visits to a mental health provider of their choice.

TIC adds another valuable method for dealing with officer stress: Critical Incident Stress Debriefing (CISD), in which involved and witness officers sit down with TIC and EAP professionals, as well as others, to discuss the deadly force incident and how to deal with its aftermath. CISD generally takes place shortly after the District Attorney's office announces that there will be no prosecution of the involved officers. TIC members regulate who attends the meeting, and typically inform the involved officers that in past meetings, it has been helpful to invite spouses/partners, older

[102] As a matter of practice, however, the PPB appears to be far more generous, typically granting paid leave to officers through the completion of grand jury proceedings — typically, one to four weeks after the incident. The PPB's practice of providing all involved witness officers with paid leave regardless of their actual emotional or physical condition is more generous than most other departments' practices.

children, other officers present at the scene, radio dispatchers, paramedics, friends, mental health professionals, and volunteer chaplains. Although supervisors are not required to be excluded, they generally are not invited.

The CISD typically takes place at a local church or community center. PPB's Employee Assistance Program provides food, as the meetings generally last between one and one-half and three hours. Typically 10 to 20 people attend the meeting. Although there is no firm agenda, most CISD's follow an outline prepared by TIC. A copy of the outline is set forth in the Appendix at page 29. Often a TIC member will begin the meeting by playing the radio broadcast from the incident itself. Officers who were involved in the incident will then recount what they saw and heard. The discussion then turns to the officers' emotional response both to the events as they unfolded and to the aftermath, including the PPB's investigation and media coverage. Those who have attended CISD's, either as participants or guests, invariably give the process high marks.

One potential concern involves the timing of the CISD session. As stated earlier, the sessions usually take place within a matter of days after the DA has notified the officers that they will not be subject to prosecution. The problem, of course, is that the administrative investigation will still be pending. If, however, the PPB adopts our recommendations to replace its current Homicide-only system of investigating officer-involved shooting and in-custody death cases, and if it further provides for prompt, comprehensive, and tape-recorded interviews by members of a redesigned investigative team, CISD sessions should be able to proceed shortly after the announcement of the no-prosecution decision without concern for potential witness contamination. If, however, such recommendations are not put into place, conducting CISD sessions prior to the conclusion of administrative review will continue to present serious risks of witness contamination and possibly even present the appearance of impropriety.

Recommendation 4.19: The PPB should establish policies that ensure that all administrative investigation interviews of involved and witness officers take place before CISD meetings have been scheduled.

III. Recommendations

In summary, we make the following recommendations regarding PPB investigative procedures.

Recommendation 4.1: The PPB should replace its current Homicide-only model of investigating officer-involved shootings and in-custody death cases with a broader, multidisciplinary approach, such as the Internal Affairs Overlay Model or the Specialist Team Model used by most major law enforcement agencies — with the Los Angeles Sheriff's Department and Washington, D.C. systems serving as examples of best practice.

Recommendation 4.2: The PPB should revise its investigative policies regarding firearms discharges at animals and non-injury accidental discharges to require supervisors arriving at the scene to immediately notify the PPB's deadly force investigation unit of the incident. The deadly force unit should either respond to the scene and take over the investigation, or be required subsequently to review the chain of command's completed investigation for completeness and objectivity.

Recommendation 4.3: The Bureau should revise its policies to make clear that investigators should *always* strive to obtain a contemporaneous, tape-recorded interview of involved officers. Such a policy would not only ease doubts about officer collusion, but place officers and civilians on the same footing. In addition, in those cases where an officer declines to provide a contemporaneous interview, investigators should be required to thoroughly document their efforts to obtain the interview, including (1) when the request was made, (2) to whom it was directed, and (3) the reason(s) for the declination.

Recommendation 4.4: The PPB should meet with the leadership of the police unions to work out procedures for taking voluntary statements from involved officers in the hours immediately following a shooting or in-custody death incident. Interviews would not be conducted until after the officers have been given an opportunity to consult

with a lawyer and/or union representative. The unions should encourage involved officers to provide investigators with contemporaneous statements, and likewise should encourage the lawyers they furnish to their members to facilitate such prompt statements.

Recommendation 4.5: The PPB should study the Phoenix system of obtaining contemporaneous statements, in which all involved or witness officers are ordered to speak to Internal Affairs investigators no later than a few hours after the deadly force or in-custody death incident, regardless of whether they have already given a voluntary statement to Homicide investigators. The IA interview, which is walled off from Homicide and the District Attorney, is used solely in connection with the agency's administrative and tactical review of the incident.

Recommendation 4.6: The PPB should issue a policy expressly forbidding all officers who participated in or witnessed an officer-involved shooting or in-custody death from discussing the incident with any person (including other involved or witness officers) other than their immediate supervisor, unit commanding officer, union representative, attorney, a medical or psychological professional, and PPB investigators until they have completed comprehensive, taped interviews in the criminal and, if needed, administrative investigations. In discussing the incident with their immediate supervisor or unit commanding officer during this period, officers should provide only that information necessary to secure the scene and identify the location of physical evidence and witnesses.

Recommendation 4.7: The PPB should issue a policy forbidding all officers from volunteering or communicating any information to involved or witness officers before the deadly force investigation has been completed. In addition, just as a judge may order jurors to avoid media and other discussions of a pending case, so too should the PPB issue a policy directing involved or witness officers to avoid exposure to other accounts of the incident (even if unsolicited) until they have provided investigators with a comprehensive, tape-recorded statement. In addition, the PPB should require its

investigators to thoroughly cover in each officer interview what information the officer had received from other officers or outside sources.

Recommendation 4.8: The PPB should require that supervisors arriving at the scene of an officer-involved shooting or in-custody death incident ask each officer at the scene what, if any, discussions regarding the incident have occurred prior to the supervisor's arrival. The supervisor should then brief investigators immediately after they arrive at the scene concerning the answers to those inquiries.

Recommendation 4.9: The PPB should require that involved and witness officers be physically separated immediately after the scene has been secured, and that the officers remain sequestered (*i.e.*, unable to communicate with each other) until they have submitted to a comprehensive, taped interview by investigators.

Recommendation 4.10: The PPB should memorialize in its policies the requirement that members of the TIC Team — and any other officer not charged with securing or investigating the scene of an officer-involved shooting or in-custody death incident — remain outside of the crime scene absent express authorization from on-scene PPB investigators.

Recommendation 4.11: The PPB should memorialize in its policies a rule expressly prohibiting members of the TIC Team — and any other officer not charged with securing or investigating the scene of an officer-involved shooting or in-custody death incident — from discussing the incident with involved or witness officers until the officers in question have submitted to a comprehensive, taped interview with PPB investigators.

Recommendation 4.12: The PPB should revise its deadly force policy to ensure that all persons who witnessed an officer-involved shooting or an in-custody death are interviewed on tape by investigators. The PPB should specifically eliminate its policy

granting Homicide the discretion to forego interviews of witness officers and rely instead on written reports. Transcripts of all interviews should be included in the case file.

Recommendation 4.13: If a civilian refuses to submit to a taped interview, investigators should (1) not begin the interview until the witness has signed a form acknowledging that he or she has refused to be interviewed on tape; and (2) present the civilian with a written copy of the investigator's summary of the interview and allow the citizen to review and sign the investigator's summary for accuracy. The civilian 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/amended witness summary should be included in the investigative file.

Recommendation 4.14: PPB investigators should video- or tape-record all scene walk-throughs with involved or witness officers. Transcripts of all walk-throughs should be included in the case file.

Recommendation 4.15: The PPB's policy and practice of conducting untaped "pre-interviews" of officers or civilians should be eliminated.

Recommendation 4.16: The PPB should improve the already useful existing Deadly Force Interview Checklist by adding policy and tactical questions, including: (1) whether the officers can think of (a) alternative approaches that might have minimized risk to themselves and others, and (b) potential improvements in PPB training; (2) a description of when and why the officers decided to (a) draw their guns; (b) point their guns; or (c) lower or re-holster their guns; (3) describing the grip and shooting stance used by the officers, including gun/flashlight technique; (4) indicating whether the shots were sighted; (5) describing the availability and use of cover and concealment; and (6) identifying distances from suspects with weapons other than guns, and opportunities for tactical retreat.

Recommendation 4.17: The PPB should also issue a policy requiring investigators to cover all areas on the modified interview checklist in all interviews.

Recommendation 4.18: The PPB should prepare an Interview Checklist, similar to the Deadly Force Interview Checklist, to be used during in-custody death and serious force investigations.

Recommendation 4.19: The PPB should establish policies that ensure that each officer who was involved in or witnessed an officer-involved shooting or in-custody death incident does not participate in a Critical Incident Stress Debriefing (CISD) meeting prior to submitting to a comprehensive, tape-recorded interview in the investigation of the incident.

5. Quality of Homicide Investigations and Reports

In addition to examining the PPB's policies and procedures for investigating officer-involved shootings and in-custody-deaths, we also carefully reviewed the case files for the 34 officer-involved shooting and in-custody death incidents that occurred in the city of Portland between January 1997 and June 2000 as presented for command level review. In Chapter 7 we discuss the policy issues raised by the PPB's response to the incidents themselves. In this chapter we consider issues related to the quality of the investigations performed on these 34 cases by the Homicide detail of the Detective Division.

As we discussed in Chapter 4, Homicide's investigation of officer-involved shootings and in-custody deaths not only assists the District Attorney and the grand jury in determining whether or not officers should be subject to criminal prosecution, but also serves as the principal source of information to PPB managers and executives charged with determining whether the officers complied with the law, followed policy, and used sound tactics.[103] Accordingly, to provide the information needed for the internal review of compliance with policy and tactical requirements, Homicide must conduct a thorough and impartial investigation and must present the evidence obtained in a clear and organized manner.

For the time period we examined, Homicide often failed to meet those expectations. We found many deficiencies with Homicide's underlying investigation, for example: evidence was overlooked, important tests were not performed. In addition, in some cases we found subtle — and in rare cases, not-so-subtle — indications of investigator bias, including improper leading questions and failures to pose obvious and/or probing questions. We also found, as discussed in Chapter 4, that Homicide's focus was often too narrow: investigators paid a great deal of attention to officers' use of

[103] The other source of information is the after-action report submitted by the commander of the unit whose officers were involved in the incident. We discuss after-action reports and the PPB review process in Chapter 6.

force and often paid relatively little attention to whether officers heedlessly walked into or even created situations requiring them to use deadly or significant force.

Homicide's presentation of the evidence in its investigative files also raised a number of problems. Virtually every case file presented to PPB executives was missing at least one piece of vital evidence or information, such as crime scene photographs, autopsy or medical reports, tapes and transcripts of radio broadcasts, and criminalists' reports. Some files lacked a great deal of key documentation.[104] In many instances, the fact that Bureau's official file did not contain the pertinent information did not mean that Homicide investigators or criminalists had failed to collect and document the evidence. Rather, the missing documentation was often contained in the detective's "personal file."[105] For the time period of our review, the Detective Division gave the individual detectives broad discretion to decide whether certain information was placed in the investigative file or the detective's "personal file." In addition, the Detective Division did not require detectives to preserve their personal files.

We discuss below these quality-of-investigation issues in detail. Our purpose in doing so is to provide the information necessary to identify recurrent problems we found

[104] We discuss these and other problems with the PPB's recordkeeping more fully in Part II of this chapter and in Chapter 8. Nonetheless, we point out here that we found no indication of any conscious effort by investigators to omit information that was unfavorable to fellow officers or to otherwise distort the findings of the investigations.

[105] Our review was necessarily based upon the records the PPB provided to us. In a minority of cases, the PPB provided us with some or all the investigators' "personal files." Also, in a different minority of cases the PPB provided us with at least some of the video and audio tapes relevant to the investigation. We were informed in July 2003 (after we had nearly completed our analysis of individual case files) that the PPB had failed to produce roughly 5,000 photographs and several dozen videotapes that we had requested nine months earlier. We requested that the missing materials be produced immediately and were able to review the materials prior to finalizing this report.

Notwithstanding the fact that at least some of the official Homicide case files under-reflect the work done, documenting the limitations of those files provides valuable insights, in that those were the only records provided to the PPB's executives in their internal reviews of such of these 34 cases as were subjected to internal review. To the extent that we highlight omissions that are the product of poor record-keeping practices, rather than poor investigative practices, our review is just one more example of the old adage: "What is not documented did not happen."

so that they can be rectified.[106] Although the problems we identify below are serious, they can be remedied by proper attention from PPB management. Other agencies with similar (or even more serious problems) have been able to reform their investigations process. We discerned no reason why the PPB cannot follow suit.

The discussion that follows is divided into four parts. In Part I we discuss the quality of Homicide's underlying investigative work. In Part II, we discuss how Homicide presented the evidence in the case file. In Part III, we recommend civilian oversight over future administrative investigations of officer-involved shootings and in-custody deaths. In Part IV, we summarize our recommendations for improving the quality of Homicide investigations and reports.

I. QUALITY OF HOMICIDE INVESTIGATIONS

A. Crime Scene Preservation and Evidence Collection

As with any investigation, the primary function of the crime scene investigator or evidence recovery technician involves the documentation and the collection of physical evidence. Because eyewitness accounts can be imperfect or biased, an investigation may turn largely, or even exclusively, upon physical evidence collected and reported by investigators.

Our ability to analyze Homicide's investigative work is limited in some regards: we were not at the scene of any of the 34 cases we reviewed and thus could not see firsthand how Homicide and PPB criminalists processed the crime scene or dealt with

[106] From what we could see, the Homicide officials assigned to these 34 cases appeared to be, by and large, competent criminal investigators. We reviewed several files that were quite good, and a few exhibiting particular skill and investigative zeal. The Homicide detail clearly possesses the skills and experience to conduct sound criminal investigations. The problems we identified in this area stem largely from poor supervision and lack of accountability. However, as noted in Chapter 4, we believe that Homicide lacks the mission and perspective to investigate policy and tactical issues relating to officer-involved shootings and in-custody death incidents. As previously recommended, the PPB should introduce to the process additional investigators who can focus on those issues.

witnesses. We were limited to reviewing the case file, the investigators' personal files (to the extent that they were available), and follow-up interviews we conducted with current and former Homicide investigators or supervisors and other PPB officials. Nonetheless, we did identify problems that need attention.

1. Crime Scene Preservation

Overall, Homicide appeared to do a good job at maintaining the integrity of the crime scene. Investigators demonstrated a full understanding of setting up inner and outer perimeters, controlling access to the scene, and organizing the collection of physical evidence and witness testimony. Still, we found a number of problems:

- In a number of cases, Homicide evidently failed to promptly direct officers unconnected with the investigation, including members of the Traumatic Incident Committee (TIC), to leave the inner crime scene perimeter.

- In one officer-involved shooting investigation, Homicide allowed an officer who had fired his weapon to be accompanied by his wife while he walked investigators through the crime scene.

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.

2. Identifying and Collecting Evidence Promptly

A time-honored maxim among crime scene investigators is that there is only one chance to search the scene properly. If evidence is missed the first time around, its value can drop considerably due to the possibility that it was moved or contaminated after the investigators left the scene. Our discussion of the PPB's evidence collection is informed in part by certain basic principles articulated by the FBI:

- The best [crime scene] search options are typically the most difficult and time-consuming.

    - Physical evidence cannot be over documented.

    - *There is only one chance to search the scene properly.*

- There are two search approaches: [1] Conduct a cautious search of visible areas, avoiding evidence loss or contamination; and [2] [a]fter the cautious search, conduct a vigorous search of concealed areas.[107]

In several cases we reviewed, PPB investigators failed to identify or locate critical pieces of physical evidence while processing the crime scene:

- In one case, investigators processing the scene of an officer-involved shooting overlooked (1) a spent shell casing, (2) a bag containing 20 rounds of live ammunition, and (3) several bullet holes. They did not locate the evidence until they revisited the crime scene *six days* later — leaving that evidence devalued as potentially contaminated.[108]

- In a second case, investigators failed to recover an ammunition magazine at the crime scene. They found the magazine a day later, but by that time the crime scene had been subject to potential contamination.

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[107] U.S. Department of Justice, Federal Bureau of Investigation, *Handbook of Forensic Services: Crime Scene Search* 2 (1999) (emphasis added).

[108] In this case the criminalists did not bring a metal detector to the scene to aid in the location of bullets and casings until six days after the shooting. The errors in this case made a difference because the PPB officers present during the incident provided inconsistent accounts that lacked critical information, such as the number of shots allegedly fired by the suspect, and the location and direction from which the suspect allegedly fired.

- In a third case, a civilian was alleged to have fired numerous times at PPB officers from his small apartment. While Homicide investigators retrieved an empty 10-round gun magazine, they collected only five of the expended shell casings.

- In a fourth case, a shooting occurred near a (non-PPB) patrol car equipped with a mobile video recorder (MVR) on the dashboard of the car. However, there was no indication in the file that investigators examined the MVR, asked about it, or took any video footage into evidence.

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.

Recommendation 5.3: Criminalists should be required to bring to the scene of officer-involved shootings and in-custody deaths all tools necessary to identify and collect physical evidence at the scene.

3. Collecting and Analyzing Gunshot Residue Evidence

Gunshot residue (GSR) evidence is widely used by law enforcement agencies across the county to help establish or confirm a person or object's proximity to a discharged firearm. Unburned gunpowder and soot expelled from the muzzle of the gun ("muzzle GSR") can be collected from various surfaces (*e.g.,* clothing, skin, hair, or hard surfaces such as doors or walls) and analyzed to help establish the distance and angle between the surface and the gun when it was fired. In addition, particles of primer, the compound that first ignites when a gun is fired, is often deposited upon the hands and clothing of the person who fired the weapon. These particles ("primer GSR") are typically collected by detectives or criminalists at the earliest opportunity after a shooting has occurred, and before the suspected shooter's hands have been wiped clean. By regularly attempting to collect muzzle and primer GSR in firearms-related cases,

investigators can enhance their ability to establish or corroborate which persons fired a weapon and where they were positioned when they fired.

The Department of Justice has taken the position that GSR analysis should be a standard part of officer-involved shooting investigations. For example, the April 2002 settlement agreement between the Justice Department and the City of Cincinnati expressly requires the Police Department to "conduct all appropriate ballistic or crime scene analyses, including *gunshot residue* or bullet trajectory tests."[109]

The PPB does not appear to test for GSR evidence as much as it should. In none of the 32 officer-involved shooting cases we reviewed was there any indication that that the PPB (1) took either muzzle GSR or primer GSR or (2) sent any already-collected evidence that might contain such GSR (*e.g.*, clothing) for analysis.

Muzzle GSR. The PPB informed us that it "routinely" takes muzzle GSR evidence in firearms cases in order to assist in determining where a gun was fired and from what angle. However, as stated above, none of the files we reviewed contained any indication that PPB investigators attempted to take muzzle GSR samples from the crime scene or submitted any materials (*e.g.*, clothing) for muzzle GSR analysis. In addition, the Oregon State Police Laboratory, which performs virtually all of the crime lab work for the PPB, could not point us to any officer-involved shooting case during our review period in which it collected or analyzed muzzle GSR for the PPB. In addition, neither the PPB nor the State Police Lab could point to an officer-involved shooting case prior to 2002 in which the PPB took muzzle GSR evidence from hard surfaces, such as vehicles, doors, or walls.

In seven (23%) of the 30 cases we examined in which shots were fired by PPB officers, muzzle GSR evidence was highly relevant, even critical:

[109] Memorandum of Agreement between Department of Justice and City of Cincinnati, ¶ 32 (April 12, 2002) (emphasis added).

- In one case, a PPB officer approached the driver of a small SUV parked on a residential street. The officer reported that he fired a single round after the driver hit the gas and steered toward him, coming so close that he actually pushed off the side of the vehicle. The suspect, however, disputed this account. There were no other witnesses. Had the PPB investigators tested the side of the vehicle for GSR, they might have been able to resolve the conflict.

- In a second, similar case, a PPB officer fired six shots at a moving SUV he claimed was only a few feet away from striking him. Once again, the suspect disputed the officer's account, and there were no other witnesses. Had the PPB tested the vehicle for GSR, it might have been able to resolve the dispute.

- In a third case, a PPB officer shot a man in the chest after he allegedly charged another officer wielding a beanbag shotgun. According to the officers, the suspect was only a few feet away when shot. A GSR test of the man's clothing could have provided an independent basis for evaluating the officers' account.

- In three other shootings, we found widely-varying accounts of where PPB officers stood in relation to suspects when they fired their weapons. Once again, GSR analysis (this time, of the suspects' clothing) could likely have assisted investigators in establishing the locations of the parties involved.

- Finally, in a seventh case, a PPB officer fired five times at an attempted murder suspect whom he reported was trying to shoot him. The officer missed, and the suspect shot himself in the head. One critical question in the investigation was whether a small, slightly irregular hole in the suspect's windshield was a bullet hole caused by a round from the suspect's gun. Homicide did not reach a

conclusion one way or the other. A muzzle GSR analysis of the hole and the immediately surrounding area may well have resolved the issue.[110]

Primer GSR. The PPB does not collect primer GSR evidence (*i.e.,* the residue often found on the hands and clothing of persons who discharge a weapon) in *any* of its firearms-related investigations, regardless of whether shots were fired by PPB officers. According to Homicide, the PPB does not take primer GSR evidence because it is inherently unreliable and thus the State Police Crime Lab will not conduct any primer GSR tests for the PPB.

We did not find this explanation convincing. While it is true that some of the early forms of primer GSR analysis (most notably, paraffin analysis) have been found to be unreliable, current methods of testing, including computer-controlled scanning electron microscopy (CCSEM) are firmly established within the literature as highly reliable.[111] In addition, most courts have deemed modern GSR tests such as CCSEM sufficiently reliable to be admitted in criminal prosecutions. *See, e.g., Mills v. Singletary*, 161 F.3d 1273 (11th Cir. 1998) (noting that "[a] majority of American jurisdictions has held the results of such tests to be admissible evidence in criminal proceedings").

In addition, the State Police Lab informed us that the reason it does not conduct primer GSR analysis is that it lacks the necessary equipment. A senior spokesperson from the Lab acknowledged that such equipment is available at nearby Portland State University.[112]

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[110] The State Police Lab confirmed that one common method for testing suspected bullet holes is to expose the affected area to (1) sodium rhodizonate to detect the presence of lead and (2) rubeanic acid to detect the presence of copper.

[111] Schwoeble, A.J. and Exline, David L., Methods in Forensic Gunshot Residue Analysis 1 (CRC Press, 2000).

[112] We were also able to confirm from a Portland-based private laboratory, whose clients include a number of law enforcement agencies in Oregon and other states, that Portland State University regularly leases time on its equipment for use in primer GSR analysis. The necessary tests cost roughly $300-500 each.

GSR evidence may not always be conclusive. However, this does not mean that the PPB should never seek to obtain it in officer-involved shooting cases. Other major law enforcement agencies, including the LAPD, LASD, and the Phoenix Police Department, regularly collect such evidence. Indeed, the LASD provides primer GSR collection kits not only to its criminalists and Homicide detectives, but also to field supervisors so that the evidence can be collected as soon as possible.

In one of the cases we reviewed, primer GSR evidence could have proven useful. Two PPB officers shot and killed a man they reported was firing at them. However, there were no other eyewitnesses and the gun alleged to have been fired by the suspect did not yield any fingerprints. Had investigators swabbed the man's hands for primer GSR (or asked representatives on the scene from the Medical Examiner's office to collect such evidence), the PPB would have been in a position to further corroborate the officers' account, as the shell casings recovered at the scene did not firmly establish that the recovered gun was fired by the suspect.

Primer GSR evidence is not only useful for the District Attorney's and the PPB's initial assessment of the shooting incident, but can reduce the City's exposure to future litigation, particularly against any claims that PPB officers planted a weapon at the scene.

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 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 primer GSR evidence in all officer-involved shooting or in-custody death cases where there is (1) some dispute about the identity of the person(s) who fired a gun or (2) 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.

4. Conducting Adequate Bullet Trajectory Analyses

Whenever a bullet penetrates a hard object, such as a vehicle, door, or wall, it is incumbent upon investigators to take evidence regarding the bullet's flight by using dowel rods, string, or a laser trajectory kit. The PPB's deadly force policy expressly requires Homicide investigators to include within their case file a report discussing "all shots fired and each shot's trajectory and point of impact (if determinable) . . . ."[113] This policy is in line with national best practices that require investigators to take bullet trajectory evidence whenever possible, even where witness accounts regarding a shooting do not appear to be in conflict.

In several of the officer-involved shooting cases we reviewed, investigators took appropriate measures to secure this evidence. Sometimes they used wooden dowels, known as trajectory rods; other times they evidently used a laser trajectory kit. Thus, it was clear that investigators were familiar with trajectory analysis and had the necessary tools to conduct it.

Notwithstanding the PPB's policy and investigators' skills, in several cases investigators did not either take or report such evidence, despite the fact that the issue of bullet trajectory was highly relevant, if not central, to assessing the propriety or tactical soundness of officer conduct. For example:

- In one case, an officer fired at a driver he claimed was about to run him over. The driver disputed the officer's account, and there were no other witnesses. One potential problem with the officer's story was that his bullet struck the driver's door, thus raising some doubt about whether the officer was still in harm's way when he fired. Thus, the bullet's angle of the entry through the car door was a critical issue. Nonetheless, for

[113] PPB Manual § 1010.10 at 408, ¶ (d)(2) (2002).

reasons not explained in the file, investigators did not present command level reviewers with a trajectory analysis.

- In a second case, another PPB officer fired a single shot at a vehicle that he claimed was about to run him over. The officer's account was also called into question because the bullet had struck the passenger door (and actually struck the front seat passenger). In this case, a PPB criminalist evidently did take evidence by inserting a trajectory rod into the car door. However, neither the criminalist's report nor photographs of the trajectory rod in place were contained in the case file. In addition, Homicide failed to specify where the officer's bullet had struck the passenger or state the bullet's angle of travel.

- In a third case, when PPB officers attempted to kick down the front door of an apartment of a man believed to be suicidal and armed with a gun, the man began shooting at the officers through his closed front door. The officers responded by firing a total of 33 rounds through the outside walls of the man's apartment. Investigators later found 10 bullet holes in the front door. The criminalists had attempted to insert trajectory rods into the door, but found the holes were too small. Rather than require the criminalists to retrieve a thinner set of rods, investigators decided not to undertake any trajectory analysis whatsoever.[114]

- In a fourth case, two officers were driving north on a residential street when a man with a gun ran eastward across the street in front of them. The officers claimed the suspect pointed his gun at them and so they fired a total of nine rounds, none of which struck the suspect. Both officers told Homicide they fired only when the suspect was in the middle of the street,

[114] The criminalists should have had a set of thinner trajectory rods available that could take evidence on holes left by .22 caliber rounds, which happened to be used in this case. In addition, if no other trajectory tools were available, the criminalists could have improvised and used string.

because they did not want any stray rounds to hit any houses on the east side of the street.[115] The suspect disputed the officers' stories. He said he did not point a weapon at the officers and was fired upon after he had crossed the street and ran northward on the east sidewalk. No one else saw the shooting.

A week after the incident, investigators found "3-4 bullet holes" in the side of a house located on the east side of the street, northeast of the officers' location. On its face at least, this evidence cast doubt on the officers' claims that they had stopped firing before the suspect had reached the east side of the street. Notwithstanding this fact, investigators elected not to conduct any trajectory analysis on the bullet holes. They did not insert any trajectory rods into the holes and did not use string or a laser kit to trace the path of the bullet hole back to the location of the officers' patrol car. Instead, the investigators offered only this statement: "The impact of these rounds appeared consistent with the direction of fire stated by Officer [A] during the post-shooting interview."[116]

In addition to choosing not to conduct a trajectory analysis, as required by Section 1010.10, the investigators did not remove the bullets from the side of the house in order to determine which officer's gun they came from — a simple matter to determine, given that one officer fired a .45 and the other fired a 9 mm handgun.[117]

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[115] One officer made this point emphatically during his interview with Homicide: "My [shooting] backdrop was the street . . . . I didn't want to shoot as he [the suspect] got near the house[s] for I didn't wanna' shoot any rounds into the two houses that were there."

[116] There were no photographs or sketches in the file that might have supported this conclusion.

[117] There were other problems with the investigation. Homicide never interviewed the owners of the home in question to determine whether they heard the impact of the bullets striking the house. Nor did they test the areas of suspected impact for traces of lead or copper. Without this information and without removing the bullets lodged in the house, Homicide could not be sure the holes were caused by PPB bullets or by any bullets whatsoever. Indeed, the case file does not contain any indication that the homeowners were ever notified of the bullet holes or Homicide investigation.

Recommendation 5.5: The PPB should enforce the requirement of Section 1010.10 that investigators conduct a trajectory analysis for every shot in an officer-involved shooting case where the bullet strikes one or more areas of the crime scene.

An aid, used by some police agencies, is the creation of a checklist that provides on-scene investigators with a detailed outline of physical evidence to be taken and analyses to be performed. Another method, used by agencies such as the Miami-Dade Police Department and the Los Angeles County Sheriff's Department for many years, is to require investigators to complete a detailed Incident Summary Form that reports key information such as distance, lighting, and weather conditions, in summary fashion. (Copies of the forms used by the LASD and Miami-Dade are set forth in the Appendix, pages 105 and 189.) Such forms serve not only as a back-up checklist for investigators, but also allow those reviewing the file to group the key facts much more quickly.

Recommendation 5.6: The PPB should develop its own checklists or Incident Summary Forms (one for officer-involved shootings and one for in-custody deaths), and require investigators, among other things, to report on the forms the trajectory of all rounds fired.

5. Scene Sketches and Measurements

In officer-involved shooting and in-custody death cases, it is difficult (and sometimes impossible) to fully assess officers' conduct without first developing a firm

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In addition, Homicide failed to follow up on other physical evidence that was inconsistent with the officers' accounts regarding the location of Officer B, who drove the car. Officer B told Homicide that he fired while still sitting in the front seat of his car, using his left (weak) hand to fire five shots out of the open door. One of the casings was on the driver's side of the windshield, tending to support this account. However, the other four casings were found in the street on the opposite side of the car, to the right (east) of the passenger door. On its face at least, this evidence cast some doubt on Officer B's account. Notwithstanding this fact, Homicide did not ask Officer B if he could explain the discrepancy and did not order any tests to determine how far and in what direction Officer B's gun ejected spent shell casings. Nor did Homicide include in the case file a sketch or memorandum that indicated precisely where the four casings were found.

understanding of the scene where the incident occurred. Accordingly, investigators must in all cases create detailed sketches of the crime scene and report crime scene measurements (*e.g.*, the distance between shell casings and an officer's patrol car, and the like).

In many of the cases we reviewed, the scene sketches were either of poor quality or were not detailed enough to enable those reviewing the file to make confident judgments about how the incident actually played out. For example:

- In one case involving an armed robbery suspect shot by a lone PPB officer, the scene sketch did not identify the location of most of the physical evidence, including five live bullets, one expended shell casing that came from the officer's gun, and a gun identified as belonging to the suspect.

  This problem was compounded by additional errors and omissions in descriptions of the scene, such as: (1) failing to describe the makes and colors of civilian cars at the scene — a serious oversight, given that witnesses typically identified the location of where key players were by referring to various cars that were next to them; and (2) misstating the location of evidence or scene landmarks (*e.g.,* investigators' scene descriptions put two cars in the exact same spot). Because the scene photographs or videotapes were not in the case file,[118] the layout of the scene was extraordinarily difficult to reconstruct.

- In a second case, officers tried to kick down the apartment door of a man believed to be suicidal and armed. The suspect fired at officers through his front door. The officers, who remained outside the apartment, fired a total of 33 rounds through one of the apartment walls. Although the file contained an

[118] As we discuss more fully in Part II below, the great majority of case files presented to PPB executives for review did not contain any photographs or videotapes. In addition, PPB officials told us that the Review Level Committee does not generally view photos or videotapes as part of the review process.

excellent diagram of the *outside* of the apartment complex, it lacked a diagram of the *inside* of the apartment, where the suspect was located and where the officers were firing.

- In a third case, a PPB officer reported that he fired at an approaching vehicle in order to save himself from being run over. The investigative file contained two scene sketches, but critical details, such as the distance between the officer's patrol car and a nearby row of hedges (which the officer claimed precluded his escape) were omitted from the sketch and not reported elsewhere in the file. Accordingly, those reviewing the file could not determine whether the officer's account was consistent with the physical evidence.

- In a fourth case, a man with a knife was confronted in a residential backyard by seven PPB officers pointing their guns at him. When one officer fired a shot from a beanbag shotgun, a second officer fired a shot from his pistol, narrowly missing the suspect, who subsequently surrendered. The officer who fired his pistol told Homicide investigators that he did so because the suspect made a threatening move toward him. The crime scene sketch, however, did not state the precise distance between the knife dropped by the suspect and the spent shell casing from the officer's pistol.[119]

- In a fifth case, a citizen died following a protracted struggle with numerous PPB officers. The struggle took place at various points along a residential street. The file contained a map of the street, but lacked a sketch identifying where any of the evidence, such as a blood spatter, or the batons dropped by a number of officers were located.

[119] This distance was not provided anywhere else in the investigative file.

- In a sixth case, a key issue was whether a fleeing armed robbery suspect was sufficiently close to an officer to present a threat sufficient to justify the use of deadly force. However, the criminalists' sketch did not represent the entire crime scene and did not contain or refer to crucial measurements, such as the distance between a blood spatter on the pavement and the spent shell casings from the officer's gun.

Recommendation 5.7: The PPB should ensure that investigators 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.

In several instances, Homicide investigators appropriately asked involved officers and civilians to draw their own sketches of the scene or annotate the sketch prepared by the investigators. Homicide, however, did not do this in every case and even when it did, it often failed to include these sketches in the case file.

Recommendation 5.8: PPB investigators should be required to ask all involved parties and all witnesses to draw their own sketches of the scene (or annotate sketches already prepared by the investigative team) during their taped interviews. In addition, investigators should ensure the witnesses note the movement of the involved parties (*e.g.,* note the positions taken by Officer A as A-1, A-2, etc.). Finally, investigators should verbally describe on tape when the witness makes or refers to a particular notation (*e.g.,* "the witness is now noting his location as B-1 on the sketch.").

6. Miscellaneous Problems

We found other instances in which investigators did not collect key evidence:

- Until the PPB revised its deadly force policy in May 1998, there was no requirement that involved officers' clothing or duty belt be collected as

evidence. Even after the rule was enacted, we continued to find instances in which investigators failed to collect this evidence.

- In three of the cases we reviewed, investigators did not adequately preserve the integrity of firearms belonging to officers involved in a shooting incident. In the first case, an officer was permitted to leave the scene of a shooting with the gun he had fired; Homicide later retrieved the weapon from the officer's locker at the precinct. In the second, an officer was permitted to leave the immediate scene and change ammunition magazines, even though the area had been secured and thus the officer had no need to reload his weapon. In the third case, PPB investigators never asked an involved officer to turn over the backup pistol he had been carrying in his back pocket.

- In another case, officers decided to make a forced entry into the house of a narcotics suspect whom they had been keeping under surveillance. When the officers forced the front door open, the suspect opened fire with an assault rifle. A critical issue in the case was whether the narcotics officers had conducted a proper criminal background check at the outset of their investigation in order to better assess the risk presented by the suspect. The officers told Homicide that they indeed generated such a report and asserted that the report showed that the resident had no prior convictions. However, this alleged report was not contained either in the case file or in any of the investigators' voluminous personal files. In addition, Homicide never stated what efforts it took, if any, to obtain the alleged report.[120]

- In another shooting case, Homicide failed to report a number of key forensic details, such as (1) how many rounds were fired by the suspect, and (2) any

[120] A computer query generated by Homicide only hours after the shooting showed that the resident did indeed have a felony record, including assault with a deadly weapon and a subsequent weapons charge resulting from an armed standoff with police officers. Moreover, this subsequently-generated report was neither included nor mentioned in the investigative file. We found the document only while poring through the detectives' personal files, which filled roughly half a dozen boxes.

evidence suggesting where the suspect was standing when he opened fire. Both issues were highly relevant, as the PPB officers fired a total of 33 rounds at the suspect through the walls of his apartment.

B. Homicide's Witness Interviews

Identifying and comprehensively interviewing witnesses is critical to an officer-involved shooting or in-custody death investigation, as it is to any investigation. Interviews allow the investigators to hear firsthand what involved persons and witnesses saw, heard, thought, and did. Combining the information acquired during interviews with the physical evidence gathered provides investigators with the information for constructing a chronological narrative of what occurred during a given incident.

We have already discussed some aspects of Homicide's interviewing of witnesses in Chapter 4. There we identified a number of PPB procedures and practices, such as delaying involved officers' interviews and "pre-interviewing," that can substantially affect the quality and credibility of interviews. Upon review of the investigative files themselves, we found additional problems that warrant close attention by PPB management.

1. Failure To Interview All Witnesses

We found a large number of cases in which Homicide investigators did not interview all known officer or civilian witnesses or tape-record interviews of certain key witnesses.

Officer Witnesses. Although the PPB's deadly force policy[121] allows Homicide to accept written statements from witness officers, investigators nonetheless generally opt to take tape-recorded statements from witness officers — a positive custom that should

[121] PPB Manual § 1010.10 at 407, ¶ (b)(3) (2002).

be elevated to a requirement in all officer-involved shooting and in-custody death cases.[122] Notwithstanding this general practice, we came across several cases in which Homicide investigators chose not to conduct taped interviews of witness officers who likely had highly relevant information to provide:

- In one shooting case involving a large deployment of PPB officers to a man-with-a-gun call, Homicide investigators failed to interview 11 officers who had responded to the call, including several who were close to the scene of the officer-involved shooting.

- In a second shooting case also involving a large deployment of officers, Homicide investigators failed to conduct taped interviews of six officers at the scene, including one officer who may have been in a position to see another officer fire six times at a suspect. The other untaped witnesses were also important, including (1) a patrol officer who helped take the suspect into custody, and (2) three sergeants who were responsible for coordinating the deployment. For reasons not articulated in the file, Homicide chose to have each officer write a report about the incident. The reports were brief and left many key questions unanswered.

- In a third shooting case, a PPB officer kicked open the front door of a dwelling and shot the suspect, who was allegedly armed with a machete.[123] An important issue in the case was whether the officer had received authorization from his sergeant to kick the door in. Although there was conflicting evidence as to

[122] We discuss the reasons that interviews with both officer and civilian witnesses should be taped in Chapter 4.

[123] The case file lacked key evidence relevant to the officer's statement, which the suspect had disputed. For example, the file did not indicate where the machete was found at the scene. Nor did the case file contain any medical files, or other evidence of where the suspect was struck, or the trajectory of the bullet wounds.

whether the sergeant gave permission to go ahead, Homicide chose not to interview the sergeant.[124]

- In a fourth case, two officers who responded to the scene of an officer-involved shooting handcuffed the wounded suspect and took him into custody. As they did so, the suspect reportedly made several statements. Homicide did not interview the two officers about the suspect's alleged statements, but merely relied upon their written reports.

Civilian Witnesses. We also found a number of cases in which Homicide investigators did not interview important civilian eyewitnesses identified in the case file or failed to video- or tape-record those interviews. For example:

- In one case, a civilian witness told Homicide that he and two companions — Civilian Y and Y's girlfriend — witnessed the events in question while seated in a car. Civilian Y, however, told Homicide that his girlfriend was not in the car that evening. Homicide did not interview the woman, and evidently made no attempt to contact her. Nor did Homicide explain why it did not seek to interview the woman.

- In another case, an officer shot a knife-carrying suspect in the presence of several civilians. Although the officer saw three civilians (whose identities another officer recorded in a report) standing across the street immediately after the shooting, Homicide did not interview them and did not explain its decision not to do so.

[124] While the case was not considered by the Review Level Committee, the issue of the officer's conduct did arise 14 months later, while the PPB's Award Review Committee was considering the officer for a commendation. Two police commanders informed the Award Review Committee that (1) the officer had been told by the sergeant to wait for the latter's arrival, and (2) in violation of that directive, the officer went ahead and kicked the door in and precipitated the shooting. The Committee ultimately declined to recommend the officer for a commendation.

- In another case, investigators located several civilians who, while they did not see the officer-involved shooting in question, did witness certain events immediately preceding the shooting. However, for reasons not explained in the file, Homicide did not interview these witnesses.

- In an in-custody death case, for reasons not explained in the file, Homicide evidently made no effort to interview 19 civilian witnesses, including one who, based upon what he told a uniformed officer, apparently saw more of the final efforts to subdue the man who died than did any other civilian. Nor did Homicide tape-record any of the 17 civilian witness interviews they did conduct, even though four of those witnesses alleged that officers had used excessive force and a fifth alleged that the officers did not call for medical treatment until five minutes after the suspect had died. Nor did Homicide tape a key interview with the Medical Examiner, which evidently was critical to the PPB's decision to clear the case.

- In another case, an investigator canvassing the neighborhood for witnesses to an officer-involved shooting identified two civilians who said they heard gunshots and officers shouting commands. For reasons not explained in the file, investigators did not ask the witnesses to submit to taped interviews.

- In another case, investigators spoke to three civilians who reported seeing a confrontation between a suspect and two officers that led to a shooting. In the summaries of those discussions, investigators quoted statements from the civilians that strongly supported the officers' use of force. For example, one civilian was quoted as saying, "Without a doubt the officers didn't have a choice. He got too close to the officers for their safety." For reasons not explained in the file, Homicide did not conduct taped interviews of either eyewitness, and evidently did not provide copies of the interview summaries to the eyewitnesses so that they could check to see if the statements attributed to them were accurate.

Because Homicide did not routinely document all of its canvassing efforts, in many cases we were unable to assess Homicide's canvassing. On the other hand, we found several instances in which Homicide evidently did not thoroughly canvass for civilian witnesses in neighborhoods where officer-involved shootings or in-custody deaths occurred. For example, one evening around midnight, PPB officers were involved in an officer-involved shooting near an apartment complex. Shortly after arriving at the scene, Homicide went to the apartment complex and began knocking on doors. Although a number of residents did not answer their doors at that time, Homicide never went back to follow-up with the unresponsive residents at a more convenient hour.

Civilian Suspects. Generally speaking, investigators attempt to interview all civilian suspects involved in an officer-involved shooting or in-custody death case. File integrity requires that investigators fully document their attempts to obtain a suspect statement and to provide an explanation as to why a suspect's interview is not included in the file. Nonetheless, in a number of files Homicide investigators did not account for the lack of a civilian suspect's statement.

2. Quality of Homicide Interviews

To its great credit, in officer-involved shooting and in-custody death investigations, the PPB generally transcribes the interviews of the involved officers and all those witnesses it chooses to tape. (Many other police agencies, including those with greater financial resources than the PPB, often do not go to the trouble of transcribing taped statements.) Transcripts are extremely valuable, for they not only provide easy access to the witness' own words, but also shed light on the quality of the interview itself. If there are accountability mechanisms in place, investigators who conduct substandard interviews may be held accountable for conducting incomplete or biased interviews.

All but one of the 34 files we reviewed contained transcripts of the involved officers and one or more other key witnesses. We found that in most cases Homicide investigators asked even-handed questions designed to elicit basic information regarding

the incident at hand. However, given the critical nature of the cases under investigation, obtaining only basic information was often insufficient.

(a) Thoroughness of Homicide Interviews

In most cases we reviewed, Homicide investigators did not conduct thorough interviews. Homicide investigators did not ask obvious questions, did not test dubious answers, and did not resolve fundamental inconsistencies between witness accounts. In some cases the oversights were relatively minor; in other cases, entire areas of testimony were not covered, leaving decisionmakers without a complete record. For example:

- Two officers in a patrol car saw a man driving an SUV fire several gunshots in the direction of a night club. After a brief vehicle pursuit, the man crashed his SUV into the back of a dump truck. The officers exited their car (which was parked well behind the SUV) and drew their guns. Because it was dark, and the windows of the SUV were tinted, the officers could not see the driver or determine if there was anyone else in the vehicle. Moments later, one officer saw the driver's door begin to open. Without seeing a weapon or the driver, the officer fired nine times, aiming all of his shots at the darkened rear window of the SUV. His partner fired three times, also directing his fire into the rear of the vehicle. Had there been passengers in the rear seat, they could have been killed or seriously injured. As it turned out, the bullets narrowly missed the driver and his passenger.

  The case presented a number of key policy and training issues, including (1) the officers' failure to give any commands to the driver; (2) their decision to open fire without seeing the driver or a weapon; and (3) aiming all 12 of their shots into the rear of the vehicle without knowing whether there was anyone sitting in the back seat. However, Homicide did not ask the officers how these decisions comported with PPB policy or training.

- In another case, an assault suspect with mental illness was wrestled to the ground by a group of PPB officers and stopped breathing. A key issue for Homicide investigators was whether officers' actions led to positional asphyxia or otherwise contributed to the man's death. Nonetheless, Homicide did not fully explore the issue in its interviews. For example, the investigators did not: (1) ask all of the officers involved in the struggle whether they had seen others placing pressure on the suspect's head, neck, or back as he lay prone on the ground;[125] (2) ask any officers about their training regarding positional asphyxia or dealing with suspects with mental illness — even though Homicide's own protocols required the investigators to ask about relevant training; (3) ask a sergeant at the scene why he did not monitor officers' restraint efforts but instead focused his attention on bystander witnesses; or (4) ask an officer who reported pressing the tip of his ASP baton against a pressure point behind the suspect's right ear whether the officer had been trained to use that technique.

(b) Focus Too Narrow

A related problem running throughout the 34 files we reviewed was that investigators focused too narrowly on the actions and decisions made at the time of the officer's use of force. Investigators often failed to thoroughly question officers about how they entered into, or even created, situations that subsequently required them to use deadly or significant force. For example:

- In one case, a group of PPB officers was in the process of planning to make a forced entry into a house when one officer spotted a video camera pointing out the front window. She then told the team leader about it. Rather than revise their entry plan, the officers went ahead and forced the front door open. Almost

[125] One officer told Homicide that when he arrived at the scene, he saw an unidentified officer with his foot on the suspect's upper back. He later stated that unidentified officers were "using body weight, hands and perhaps knees, and shins with body weight to hold [the suspect] down" in a prone position. Homicide did not, however, ask all of the officers on the scene whether they had taken such measures or had seen others do so.

immediately they were met with a volley of gunfire from the suspect, who had been watching the officers on a video monitor. A key issue in the case was why the officers did not change their entry plan once they learned of the surveillance camera. Homicide, however, did not broach the subject in any of its interviews.

- In another case, a PPB officer fell to the ground while he and another officer were struggling with a heavily intoxicated man in a motel room. Though not injured or stunned by the fall, the officer remained on the ground while the suspect straddled the other officer and continued to fight with her for some moments. Finally, the first officer pulled his gun and shot the suspect once in the head, killing him. When asked why he did not use his ASP baton, the officer replied that he could not retrieve his ASP because he was lying on his left side. Homicide did not follow up by asking the officer why he did not get up off his left side so that he could use his ASP or a variety of other non-lethal force options, such as punches, kicks, or restraint holds.

Indeed, the great majority of the cases we reviewed presented questions regarding training, tactics, and professional judgment. Yet almost invariably Homicide did not adequately explore these issues in its interviews or in any other portions of the investigative file. This narrow focus illustrates why the PPB should replace the Homicide-only model of investigation with a model designed to fully explore policy and tactical issues.

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.

(c) Leading or Biased Questions

In most interviews, Homicide followed a standard, acceptable format: (1) asking the witness to provide a full narrative of the event; (2) asking follow-up questions; and (3) summarizing or clarifying previous statements by the witness.

Investigators following this format are likely to ask a number of leading questions: regarding minor matters to speed the interview along (*e.g.*, "You work afternoon shift at Central Precinct, correct?"); and to summarize or clarify previous testimony (*e.g.*, "So let me see if I have the sequence correct. Once the suspect's car crashed, you got out, drew your gun, and yelled for the suspect to show his hands, is that right?"). Nonetheless, some categories of leading questions — such as questions designed to suggest how the witness should respond — are improper. Such questioning not only affects the integrity of the interview, but creates doubt about the investigator's underlying motives or bias.

In many of the files we reviewed, we found both proper and improper leading questions, including, in the latter category, questions that were clearly designed to elicit testimony favorable to the officers under investigation. In a few cases, investigators kept pressing forward with such questions even where it was clear that the witness was disinclined or unable to provide the hoped-for answer.

Leading Questions Posed to Officers. One of Homicide's key tasks in officer-involved shooting and in-custody death cases is to obtain evidence of the involved officers' mental state. However, in some cases, investigators posed questions that were unnecessarily suggestive. For example:

- In one shooting case, an investigator asked a PPB officer, "Did you at any time believe that you, or Officer [B], might be seriously injured, or killed?"

- In a second case, an officer fired at a burglary suspect whom the officer stated was reaching for his waistband. (The suspect turned out to be the owner of the residence who was unarmed and innocent of any wrongdoing.) During the officer's taped interview, the investigator asked, "In your experience, do people who carry weapons normally carry them in an area near their waist or easily accessible around their waist area?"

- In a third case, a suspect died after a sustained fight with numerous officers. While interviewing one officer who had used force on the suspect, a Homicide investigator stated: "Okay, you also mentioned your concerns for public safety if the suspect were to escape. Were you also concerned about the safety of your fellow officers when you first arrived at the confrontation?"

- In a fourth case, an investigator posed improper leading questions to most of the officers at the scene, such as:

    - "Were you at any time placed in fear that you might be injured?"

    - ". . .[W]ere you [in] fear for any individual — yourself or anyone else?"; and

    - "Okay, and you were afraid that [the suspect] was going to run over you?"

- In a fifth case, two non-PPB officers shot an unarmed attempted murder suspect in the back while he was fleeing. PPB Homicide used leading questions to prompt both officers to say that they believed the suspect was reaching for a gun:

    Investigator: Did it appear that he [the suspect] was reaching for something?

Officer 1: Yes.

Investigator: Okay. What did you think it was?

Officer 1: Well, I-I . . . .

Investigator: What did you think it might be?

Officer 1: I assumed that he would be reaching for the gun that I knew he still had someplace.

. . . . .

Investigator: Did you feel there was some likelihood that . . .

Officer 2: There was a strong likelihood that he was armed and . . .

Investigator: Did you feel a potential risk to yourself and/or your partner from that?

- In a sixth case, one Homicide investigator appropriately used a neutral question to discern an officer's mental state when he fired his gun: "[A]t this point, let's talk about how you felt at the time the incident occurred . . . ." The officer discussed some of his thought processes, but did not respond that he feared for his life or his partner's. The second interviewer returned to the issue by asking: "*[F]rom your training and experience, and predicated upon what happened this night, did you, do you believe that this person could have seriously injured or killed either you or Officer*

[B] during the course of these events?" (emphasis added). The officer replied, "Absolutely," and the interview soon drew to a close.

In other cases, it appeared that Homicide investigators were using leading questions to elicit information previously provided to them during the untaped "pre-interview" or during an untaped walk-through of the scene. For example, in one case, a Homicide investigator began the taped interview of an officer by noting, "[A]s you know we've been over this fairly exhaustively already, I'd like to just do it again for the tape . . . ."[126] Later in the interview, the Homicide investigator appears to use information gleaned from the untaped pre-interview to correct some details in the officer's taped statement. For example:

Officer: . . . I got to the front yard I saw the suspect running east and north across . . .

Investigator: You mean north and west.

Officer: That's right, north and west . . . .

Because pre-interviews are untaped, neither we nor anyone in the PPB can be sure whether such questions or statements are proper. As we discussed in Chapter 4, the PPB should eliminate the practice of conducting untaped pre-interviews so as to reduce the number of leading questions and to eliminate any appearance of impropriety.

Potentially Biased Questioning Of Civilians. In most of the 34 cases we reviewed, Homicide did not pose inappropriate leading questions to civilian witnesses; however, the non-PPB members of the East County Major Crimes Team who were assisting PPB Homicide detectives did pose such inappropriate questions. Because PPB Homicide maintains control over the investigation, it is ultimately answerable for the

[126]Neither the content nor the circumstances of this earlier "exhaustive" interview are indicated in the case file.

conduct of non-PPB investigators during investigations. For the time period we studied, however, it appeared that the PPB either did not notice (or did not address) overt attempts by non-PPB members of the Major Crimes Team to try and use civilian interviews to shape the record in a light that was favorable to the officers involved. Consider for example, this exchange between a non-PPB investigator and a civilian who witnessed a fight between PPB officers and a motel resident that ended in the fatal shooting of the resident:

Investigator: Did you see the decedent with a gun?

Witness: No, I didn't see him with anything.

Investigator: *Could they, could he have had a gun?*

Witness: He could've had a, yeah, I guess, he could've had 4 or 5 guns, but I didn't, ya know.

Investigator: *Could he have had the officer's gun, or could he have been struggling over the gun?*

Witness: Mmm, I guess that's possible, that's possible . . . . (Emphasis added.)

Once the witness unequivocally stated that he did not see the suspect with a gun, the investigator should have moved on. Instead, his insistence upon seeking an admission that it was "possible" for the suspect to have had a gun, casts doubt upon the investigator's impartiality. As it turned out, the suspect was unarmed. We found no indication that PPB Homicide either noticed or addressed the improper questioning.

In a second case, a non-PPB investigator on the Major Crimes Team appeared to try and minimize the "negative" impact of a statement by a civilian witness:

Investigator: Okay. Was, now, was, is he [the suspect] resisting? Is he . . .

Witness: I don't . . .

Investigator: . . . was he, was he, could you tell if he was fighting?

Witness: No, he was not fighting. He was not resisting, he was . . .

Investigator: *Okay. At least to you, it didn't look like he was fighting. . . .*

Witness: Right. At least to me. (Emphasis added.)

Once again, even though PPB Homicide was responsible for the quality and integrity of the interview, we found no evidence Homicide detected or sought to address the problem in the above interview.

Recommendation 5.10: PPB investigators should identify and conduct thorough, unbiased, and tape-recorded interviews of all witnesses — including emergency and medical professionals[127] who performed examinations or rendered treatment — in deadly force or in-custody death incidents. They 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.

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. If the PPB requires practical guidance on how to document

civilian interviews where taping is refused as described above, it may wish to confer with members of the Metropolitan Police Department's highly-regarded FIT Team, which follows a similar procedure.

II. HOMICIDE'S PRESENTATION OF EVIDENCE

As part of our study, the PPB provided us with copies of case files presented to PPB officials for command level review. Thus, we saw what the Bureau executives saw. Perhaps equally importantly, information not presented in our copies of the case files was also not presented to the executives.

We found many problems with the files themselves. It was a matter of concern that these problems did not prompt executives to institute changes to the way that Homicide functioned. As with Homicide's investigative work, its presentation of the facts was marred by problems that were systemic and persistent over time. That is to say, problems that regularly surfaced in files from 1997 also surfaced in files from 2000.

It is also important to note here, as we have stated earlier in this chapter, that it did not appear that investigators were consciously omitting from the case files information that was unfavorable to the involved officers. Indeed, often the omitted materials either tended to support the officer's account or were neutral.

A. Missing Information and Evidence

Most of the case files were missing one of more pieces of highly relevant, if not critical evidence. For example:

[127] Although investigators need not tape-record their routine discussions with pathologists, in those cases where they feel the need to interview such professionals, they should seek to have those interviews tape-recorded.

- 29 (85%) of the 34 files did not contain any photographs of the scene, suspects, or officers; [128]

- 26 (76%) of the case files did not include a videotape of the crime scene;

- 32 (94%) of the case files failed to include readily available computer reports that set forth the involved officers': (1) training courses completed; (2) assignment history; (3) prior shootings, if any; or (4) prior discipline or pending investigations.[129]

- Of the eight cases involving a civilian fatality, three (38%) did not include the autopsy report in the case file.[130]

- Of the 26 cases involving nonfatal civilian injuries, 23 (88%) of the case files did not contain any medical records or any report indicating that investigators sought to obtain such information.

As we discuss in Chapter 8, in some cases we were able to obtain the original "personal files" of various Homicide investigators, and in a few instances the City provided additional files relating to lawsuits that followed some of the incidents. Although, on occasion, we found relevant evidence that had not been included in the file

[128] The PPB advised us in July 2003 that 5,000 photographs and the videotapes of all but two of the crime scenes were in the archives of the Identification Division. Despite the fact that the Bureau in fact possessed this evidence, it was not part of the investigative file and thus was not presented to the executives of the Bureau in their review of these cases.

[129] Although Homicide investigators often, but not always, asked involved officers to describe their training and assignment history during interviews, none of the officers provided a full account of their training, and some failed to provide a complete and detailed chronology of their assignment history. In addition, Homicide interviewers generally did not ask the officers about prior shooting incidents or any history of complaints or discipline. Even if investigators were to routinely inquire into these matters during interviews, they should nonetheless obtain the computerized reports so they can ensure the officers are providing a full and accurate account. In addition, these reports allow executives to learn officers' histories at a glance, rather than scanning through a transcript to find the officer's statements on these subjects.

[130] In one case where the autopsy report was included only in the detective's "personal file," half of the report's pages were missing.

provided for administrative review, Homicide was unable to explain why the information was not included in the official files. In addition, PPB officials confirmed that these missing materials had not been part of the review process.

Other oversights also raised issues:

- In a number of cases, investigators asked officers or civilians to mark on a sketch of the scene their location as well as the location of others or physical evidence. However, with only a few exceptions, these annotated sketches were not included in the case file.

- The files for both of the in-custody death cases we reviewed did not contain the toxicology reports ordered by the Medical Examiner, and there was no reference to that report in one of the files.

- In one case, Homicide investigators obtained a search warrant so as to conduct a bullet trajectory analysis. However, the file did not report the results of that analysis or even state whether it had been performed.

- In three cases, Homicide failed to report the precise location of shell casings left by two PPB officers.

- In another case, a PPB officer fired into the side of a suspect's vehicle. He told Homicide that he was trying to prevent the driver from running him over. The investigative file noted that the bullet hole to the car door had been photographed. However, none of the photographs was in the file. The file also noted that a criminalist had inserted a wooden dowel into the bullet hole to demonstrate the bullet's trajectory and photographed the dowel in place. However, the file contained no photos or videotape of this procedure, and there was no memorandum from the criminalist confirming he had

conducted the analysis, and if so, what he found. Later in the same file, a detective mentioned a test fire of the officer's weapon had been requested, but the results of the test firing — if it in fact took place — were likewise not in the file.

- In another case, a PPB officer shot a suspect running toward his partner, who was carrying a beanbag shotgun. The officer told Homicide that one reason he fired his pistol was that the suspect seemed impervious to the four beanbag rounds fired at him — including one beanbag round he claimed had struck the suspect in the groin from a range of "three or four feet, tops." It was therefore incumbent upon Homicide to ascertain whether the suspect had indeed suffered a beanbag injury to the groin or anywhere else. However, while Homicide reported (in the detective's personal files though not in the case file), the nature of the bullet wound to the suspect, it failed to report anywhere whether the suspect had suffered any injuries from any beanbag rounds.[131]

Recommendation 5.11: The investigative file for an officer-involved shooting or in-custody death should include all relevant evidence and information.

B. Investigative Summaries

In none of the 34 cases we reviewed did Homicide provide a comprehensive summary of the evidence collected or mention whether certain witnesses' accounts were consistent with others' or with the physical evidence. Indeed, in all but a handful of

[131] Indeed, neither the case file nor the investigators' personal files indicated that the investigators had taken any steps to collect such evidence by taking photographs of the suspect, obtaining medical reports, or interviewing medical personnel.

Because the muzzle velocity of the PPB's beanbag shotgun rounds is approximately 200 miles per hour (300 feet per second), any of the beanbag strikes, particularly the one alleged to have struck the suspect in the groin at a range of 3-4 feet, should have produced a visible injury.

cases, there was no summary at all. As a matter of general practice, Homicide does not present the file with any summary, analysis, or commentary.

In those instances where Homicide detectives did provide some summary accounts, the summaries did not cover all of the evidence. Instead, they typically consisted of a brief narrative of investigators' actions at a particular time or at a particular location.

In addition, a number of these limited summaries did not provide an impartial account of the evidence, despite Homicide's duty to present evidence in neutral fashion. For example:

- One investigative memorandum stated that two PPB officers were fired upon by a suspect — a fact that, if true, would have made the officers' use of deadly force quite reasonable. However, there was no evidence that the officers were taking fire and the officers themselves did not allege that they were.

- In a second case, Homicide summarized a shooting incident in conclusory terms:

> The investigation has established that . . . [Officer A] became involved in a high-speed pursuit of a vehicle operated by [Civilian B] accompanied by his friend, [Civilian C]. During the pursuit, [B] attempted to run down [Officer A] who had exited his police car, prompting [him] to fire multiple rounds at the vehicle in an effort to stop [B].

  The summary did not, however, mention several key facts that seemed to undermine this conclusion. For example, Officer A fired his first three shots while standing next to B's door. In addition, Homicide did not mention that

the officer's account of the incident did not square with the location of the shell casings fired from his gun.

- In a third case, involving an in-custody death, Homicide took the unusual (and laudable) step of including a summary of witness interviews it had conducted in the case. Unfortunately, however, the summary was replete with problems. First, it failed even to mention the statements of nine civilian witnesses, including three who claimed the officers used excessive force and three who saw the civilian trying to assault the officers. Second, in summarizing the interviews of two civilians, Homicide failed to mention that they (and two other witnesses) claimed that a PPB officer appeared to deliberately injure the suspect after the suspect had been handcuffed and was unconscious. Third, Homicide failed to mention that two of the officers interviewed admitted to using force that may have impeded the suspect's ability to breathe, including an effort to "hog-tie" the suspect. Finally, Homicide failed to mention that several civilians identified in its summary alleged that a PPB officer used excessive force on two civilian bystanders

PPB practices are inconsistent with other major police agencies, which require investigators to provide a comprehensive summary in every case. For example, the Miami-Dade Police Department and the Los Angeles County Sheriff's Department include within each file an Incident Summary Form that succinctly conveys key evidentiary information, such as:

- Physical description of involved officers and civilians, including age, height and weight;
- Weapon and ammunition involved;
- Whether the officer's weapon and ammunition were authorized;
- Basis for encounter (e.g., traffic stop, radio call, citizen flagdown);
- Number of shots fired and number and location of hits;
- Injuries sustained;

- Date of officer's firearm qualification;
- Training history;
- Prior shootings, discipline or administrative investigations
- Lighting conditions;
- Weather and visibility factors; and
- Type of location (residence, street, park)

Copies of the LASD and Miami-Dade forms are set forth in the Appendix, pages 105 and 189. Such forms not only serve to provide executives with key information at a glance, but also serve as an informal checklist for the investigators themselves.

These and other agencies require their investigators to specifically identify when a particular statement by a witness or involved officer is contrary to the statements of other witnesses or inconsistent with the physical evidence. The LAPD takes the additional step of requiring its investigators to include within their summary memorandum a list of all factual issues in dispute as well as the evidence that might support or negate each disputed issue.

Recommendation 5.12: Each investigative file should contain a detailed, comprehensive summary of the investigation. Although the summary

Missing Documents: A Case Study.

We have already mentioned that Homicide detectives responsible for investigating an officer-involved shooting or an in-custody death maintain so-called "personal files" containing their handwritten notes, unused photographs, and duplicate reports.

We found, however, that these "personal files" often contained vital information that was not contained with the official case file presented for administrative review of the incident. For example, when reviewing one 1998 case we found the following materials in investigators' "personal files" that were ***not*** included within the official case file:

- The sketch of the crime scene;
- Photographs of the scene and the involved parties;
- A report of the suspect's height and weight — a piece of information that was highly relevant to testing officers' claim that deadly force was used to prevent the suspect from overpowering them;
- A memorandum from a Homicide investigator describing a bullet wound to the suspect, as related to him by a hospital nurse. (The investigative file contained no interviews with hospital staff or any description or other documentation of the suspect's injuries.);
- A detailed summary of investigators' interview of the citizen who had placed the original 911 call for help;
- Investigators' forms showing the extent of their efforts to canvass the area for witnesses. (These forms did not appear in any of the 34 investigative files we reviewed.);
- An arrest report showing that the suspect had been cited for public intoxication only days before the shooting. (Although the investigative file briefly referred to this report, the report itself was not included.);
- A photographic lineup including the suspect that was presented to a civilian witness;
- A Training Division printout of the involved officers' training records; and
- A computerized printout of officer communications immediately before and after the shooting.

Comparison of such "personal files" as we received with the official files did not suggest that the inclusion or exclusion of documents from the official file was motivated by bias or content-driven decisions. Rather, it appears that, with the exception of police reports and a few other types of documents required to be in the investigative file, the PPB gives investigators discretion as to what to include in the official file. As a result the official files end up incomplete in many important respects. That incompleteness could make a difference in the conclusions that any decisionmaker — whether the grand jury, the Review Level Committee, or an outside reviewer — reaches when reviewing in a particular officer-involved shooting or in-custody death case.

should be impartial and take a neutral tone, it should also identify inconsistencies between statements and inconsistencies between statements and physical evidence.

C. Documents Not Indexed or Numbered

The PPB case files presented to us were not page-numbered sequentially or indexed. Most other major agencies we have encountered take the simple step of numbering every page in the investigative file to ensure that each copy is intact and to allow citations to relevant evidence by page number. We recommend that the PPB follow suit and begin to number and index every investigative file for officer-involved shooting and in-custody death cases.

Another best practice the PPB should adopt is the inclusion of an "Investigator Log," in which each investigator provides a chronological listing of his or her case work. Such logs can be invaluable. 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. An example of an Investigator's Log is set forth in the Appendix, page 114.

Recommendation 5.13: Completed investigation 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 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.

III. A REMEDY

We have not examined any officer-involved shooting or in-custody death files for incidents that took place after mid-2000. Accordingly, we are unable to say whether the pervasive issues concerning the quality of the investigations from 1997 to 2000 continue to the present time. We do know, however, that in our conversations with PPB officials we have not learned of any significant changes in procedures or in accountability that have occurred since the period of our review. We thus suspect that many of the issues concerning completeness and even handedness that we found in the investigative process from 1997 to 2000 continue today.

The City of Portland commendably decided two years ago that Internal Affairs cases are important enough to be monitored by the Independent Police Review Division (IPR) of the City Auditor's office. These cases include rudeness and failures to follow procedures, such as filling out reports.[1] Without in any way denigrating the extremely important issues within the jurisdiction of Internal Affairs, if investigations of rudeness and failure to follow procedures — as well as considerably more serious misconduct complaints — are worthy of civilian oversight, then surely investigations of officer-involved shootings and in-custody deaths merit such oversight. This is true even without any indications of problems in the process. But, as we have documented, there are strong indications of current problems in the fairness and thoroughness of investigating these cases — cases which sometimes involve individuals being shot or killed. It thus seems anomalous that Portland would not have at least as much civilian oversight in officer-involved shootings and in-custody death investigations, as it has in Internal Affairs investigations.

Because IPR already performs a similar oversight role for Internal Affairs investigations, expanding its jurisdiction may be the logical way to proceed. We leave the precise mechanism for implementing this recommendation, however, to the elected leaders of the City of Portland. The essence of our recommendation is that detailed, knowledgeable, confidential scrutiny from outside the PPB is required to ensure the integrity of Bureau administrative investigations of officer-involved shootings and in-

[1] PPB Manual, § 330.00, IAD Complaint Categories, at 81-82 (2002).

custody deaths. For our recommendation to be effectively implemented requires that the civilian oversight mechanism, at a minimum, be:

- Directed and staffed by people with legal, law enforcement, and other similar professional backgrounds who have the sophistication, experience, judgment and credibility to quickly identify problems in the investigative process (if possible before they become too serious) and to influence and persuade the PPB to strive for the excellence in this critical area of which it is capable.

- Funded sufficiently so that it may credibly oversee and influence the entire administrative process from rollout to the scenes of incidents, to interviews of witnesses, to the drafting of summary reports and recommendations.

Without those two characteristics, the recommended oversight mechanism would be unlikely to succeed.

Recommendation 5.15: The City of Portland 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.

IV. RECOMMENDATIONS

Based upon our findings concerning the quality of officer-involved shootings and in-custody death investigations, the PPB is likely to benefit by implementing the following recommendations:

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.

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.

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.

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 primer GSR evidence in all officer-involved shooting or in-custody death cases where there is (1) some dispute about the identity of the person(s) who fired a gun or (2) 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.

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.

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.

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 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.").

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.

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 summary should be included in the investigative file.

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; (c) all autopsy, toxicology, and medical reports obtained by investigators (or a memorandum explaining why it was impossible to obtain such reports); (d) transcripts and audiotapes of all 911 calls and radio broadcasts (as well as relevant MDT transcripts); and (e) 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.

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.

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 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.

Recommendation 5.15: The City of Portland 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.

6. Internal Review

Police agencies should review officer-involved shootings and in-custody deaths with two primary goals in mind. First, they must hold their officers accountable: after mastering all of the pertinent facts they must carefully assess whether the involved officers and/or their supervisors and commanders have violated any agency policy or procedure or have acted in a manner inconsistent with their training. Second, they must use the incident as a learning tool: those charged with reviewing the case must determine what lessons can be learned from the department's experience with critical incidents and should use those lessons to inform and improve the department's policies, procedures, training, and management. As a basic requirement for effective, respectful policing, a meaningful review process engenders trust from the community served by the agency, enhances officers' safety, and leads to less frequent and more judicious uses of deadly force.

The Department of Justice has defined this two-pronged analysis as a best practice:

> An internal … review should be conducted of all firearms discharges by officers … and of any other use of deadly force. …
>
> The review should determine whether the firearms discharge or other use of deadly force: was within agency policy and reasonable and necessary, and if not, whether and what discipline should issue; indicates a need for additional training or counseling, or any other remedial measure for the involved officer; and suggests the advisability of revising or reformulating agency policy, strategy, tactics, or training.
>
> To the extent possible, the review of use of force incidents and use of force reports should include an examination of the police tactics and

precipitating events that led to the use of force, so that agencies can evaluate whether any revisions to training or practices are necessary.[133]

I. Overview of the PPB Review Process

For the time period we studied, January 1, 1997, through June 30, 2000, the PPB used a two-tiered system of administrative review. The first level of review, also known as unit-level review, comes from the involved officers' chain of command. The involved officers' unit commander is responsible for preparing a written analysis of the incident, known as an after action report, which is then forwarded to the Assistant Chief in the involved officers' chain of command for review and comment. The second, or executive, level of review, the Review Level Committee, requires an independent assessment of the incident (and the analysis set forth in the after action report) by a panel comprised of (1) all of the Assistant Chiefs in charge of the PPB's various branches, (2) the involved officers' unit commander, and (3) several non-voting members. The Review Level Committee meets to discuss the incident and then issues recommended findings to the Chief. This two-tiered system remains in place today.

In this chapter, we will examine each level of review in some detail and then briefly touch upon the separate, but related, process for determining whether to recommend officers for Bureau awards.

Overall, we found the PPB's system to be fundamentally sound and well within the mainstream of law enforcement practice. Although we found some room for improvement (which we discuss below), the system can and should generate meaningful review. The problems we found related to the PPB's operation of the system. For the time period we examined, the PPB did not demonstrate a solid commitment to reviewing officer-involved shooting and in-custody death cases with an eye toward full

[133] U.S. Department of Justice, Principles for Promoting Police Integrity: Examples of Promising Police Practices and Policies, at 5 (2001).

accountability or improving the Bureau's performance in the future. No review system, however elaborate or cutting-edge, can work unless such commitment exists.

A senior officer at the PPB, corroborated by several other ranking officers, told us:

> For some 20-odd years, people [at the Bureau] have had a hard time taking a critical look at the use of deadly force. No one wants to take action that hurts anyone's feelings.
>
> . . . .
>
> In after action reports, we are hesitant to be critical. … We hate to call each other on the carpet.
>
> . . . .
>
> There's not administrative review in this organization. People are afraid to ask hard questions. People are afraid to hurt feelings.

The senior officer's blunt assessment was echoed by colleagues, and, more importantly, his opinion was corroborated by documents we examined and facts we learned about the review process from 1997 to mid-2000.

The lack of commitment we saw for the 1997-2000 time period was evidenced by the fact that PPB officials did not comply with their own review system nearly half the time. More than 40 percent of the cases we examined were not presented to the Review Level Committee.[134] In addition, nearly 40 percent of the time unit commanders failed to comply with a PPB policy requiring them to critique their officers' actions in an after action report.[135] In those cases where an after action report was prepared, more than half

[134] Specifically, of the 32 cases that should have been submitted to the Review Level Committee, 14 (44%) were not. The PPB informed us that four of these 14 cases did receive some internal review. However, because these four reviews did not follow established procedures and the PPB provided us with very little information about these *ad hoc* reviews, it was impossible for us to assess whether the reviews were adequate.

[135] Specifically, of the 32 cases that should have resulted in the creation of an after action report, 12 (38%) did not.

were not prepared by unit commanders, in contravention of PPB policy. Moreover, many of the after action reports were cursory and uncritical.

The Review Level Committee keeps few records and the PPB cannot document any of the positions or concerns expressed during its meetings about officer-involved shootings.[136] The committee's procedures deprive it of the best evidence of what occurred during the course of an incident and most cases that were considered were determined on an incomplete record. Moreover, the fact that the committee did not identify or attempt to address the numerous deficiencies found in Homicide's investigations of the cases — a topic we discussed in Chapter 5 — indicates that the Review Level Committee did not review the cases as carefully as it should have.

II. After Action Reports

A. PPB Policy

The PPB's procedure for unit-level review of officer-involved shootings and for preparing an after action report is set forth in Manual Section 1010.10, which provides:

> After the investigation is completed by … Detectives, [unit commanders][137] will obtain copies of all reports and documents. These items, and a memorandum written by the [unit commander] discussing the investigation, will be forwarded to the appropriate [Assistant Chief].[138] The memorandum will contain the following information:

[136] It did not consider either of the in-custody death cases that are part of our study.

[137] The Manual uses the term "RU manager" for "Responsibility Unit Manager." We will use "unit commander" in our discussion as it will be more widely understood outside the Bureau.

[138] The Manual uses the term "branch manager." We will use "Assistant Chief" as that term will be more widely understood outside the Bureau.

1) A narrative which briefly and concisely outlines the incident.

2) A conclusion that indicates whether the situation fell within the guidelines of the Bureau's policy and procedures.

3) A critique that describes the manager's opinion as to whether or not the situation was handled properly and, if not, how it could have been handled.

4) Recommendations related to policy, procedure and training.

… Each level of command will review and concur with the report or make additional recommendations or suggestions.[139]

The predecessor provision that was in effect from January, 1997 until May, 1998 was identical in substance and nearly identical in its language.[140]

Both policies are generally appropriate. The PPB should expect unit commanders to carefully examine officer-involved shootings that occur on their watch both for policy compliance and for potential improvements in the future. Because most officer-involved shooting incidents occur in a patrol setting, both versions of the policy can serve to provide the PPB with a practical, field operations-oriented assessment.

Recommendation 6.1: The PPB policies relating to reviews of deadly physical force — both after action reports and Review Level Committee — should be explicitly extended to in-custody death incidents.

B. Compliance with PPB Policy Requiring After Action Reports

Twenty of the 30 PPB officer-involved shooting case files we reviewed included some form of after action report from the responsible unit. After action reports were not

[139] PPB Manual § 1010.10 at 409, ¶ e(2) (2002).

[140] General Order 1010.10, Appendix A, at 3 (September 13, 1993).

included in ten of the PPB officer-involved shooting, or in either of the in-custody death, case files we examined. Although neither unit commanders (nor their subordinates) complied with the requirement to complete an after action report in 38 percent (12 of 32) of the files we reviewed, it does not appear that anyone was held accountable for this breach of policy. And, because receipt of the after action report triggers the calendaring of cases for executive review, none of these 12 cases received review at the Review Level Committee.

Recommendation 6.2: The PPB should ensure that after action reports are completed in all officer-involved shooting and in-custody death cases, and that unit commanders are held accountable if the reports are not completed in a timely fashion.

Of the 20 after action reports that were written, a slight majority (11 of 20) were not prepared by the unit commander as required by Section 1010.10. Of the 11 where the commander did not author the report, seven sergeants and four lieutenants did so. Although there were notable exceptions,[141] by and large the unit commanders were more analytical than their subordinates. They were also more likely to critique officers' tactics, as required by Section 1010.10. For instance, in a report where a sergeant correctly identified a strategic error made by two officers, the sergeant wrote, "[The] point I want to make is a comment, not a judgment for I was not at the scene."

The drafting of after action reports by subordinate officers often created another problem: a conflict of interest. Six of the 11 after action reports drafted by subordinates were written by a supervisor who had been directly involved in the incident. As such, these sergeants and lieutenants were in a position of assessing whether their own actions, or the actions of those operating under their supervision, were consistent with policy and

[141] As discussed below, the highest quality after action report in the files we examined was written by a lieutenant.

procedure, as well as whether the situations in question were handled properly. None of these six reports found any flaws in the author's performance.[142]

Recommendation 6.3: The PPB should enforce its policy that requires unit commanders, rather than their subordinates, to prepare and sign after action reports in deadly force cases.

C. Quality of After Action Reports

Our review of the 20 after action reports that were written showed two instances of excellent work, where the incidents were carefully analyzed and appropriate lessons drawn. In the first case, the lieutenant writing the after action report structured his report around the four elements of an after action report set forth in Section 1010.10. After beginning with a clear, concise, detailed narrative, he made conclusions that the involved officer's actions had been in compliance with four specific state statutes and the Bureau's policies. He then critiqued the police action taken. While that critique was generally positive (appropriately so), he identified weaknesses where they occurred. Finally, in the most impressive part of the memorandum, the lieutenant made seven clear, thoughtful, tactically conscious, empirically supported recommendations of how the lessons from the incident should be applied in future situations and focused on in training.

The other instance of excellent after action analysis began with a sergeant's full report on the incident. The sergeant identified a number of tactical errors made by the officer that unnecessarily put the officer in danger and led to the discharge of a shot. The precinct commander followed with a separate memo that clearly laid out three "poor tactical decisions" made by the officer. A few weeks later a sergeant in the Training Division analyzed the incident for the Division commander, in preparation for the Review Level consideration of the case. The sergeant discussed the same errors the

[142] The problem of supervisors who were involved in the incident writing after action reports evaluating their own performance has re-occurred within the past year. We were told of several memoranda that a Bureau official wrote criticizing the practice. (When we asked for copies of these memoranda, we were told that they could not be located.)

precinct commander had set forth. He labeled one a "serious error of judgment" and pointed out how the tactic employed contravened the PPB's training. The sergeant went a step further in his critical analysis by explicitly stating that he did not believe the officer's account on a particular point and explaining why he found the claim unbelievable. While this was the only such memo we saw from the Training Division in the cases we reviewed, it positively contributed to the review process.[143]

Recommendation 6.4: The PPB should create a model after action report — from an actual or a hypothetical case — to demonstrate to unit commanders both the form and type of analysis that such reports should employ.

In addition to excellent work in after action reports, we also found problems in the quality and completeness of many of them. Three of the reports were written within one week of the incident and two more within 15 days of the occurrence.[144] Part of the purpose of the after action reports is for the unit of involvement to take into account what Homicide has developed in its investigation. After action reports written six or seven days after the incident are drafted before the investigative file becomes available and thus are written without making use of the information the detectives have generated during their investigation. But the after action reports that were written after the investigations had been completed did not take full advantage of the investigative findings. Despite the policy requirement that after action reports "discuss" Homicide's investigation, there were only two very brief mentions of the investigative files in the 20 reports we reviewed. Moreover, once the after action reports were drafted, copies were not sent to the detectives who investigated the case. Including the investigator in the distribution would help to ensure the accuracy and completeness of the after action reports, as well as providing Homicide with feedback on the usefulness of their investigative files to the subsequent stages of the review process.

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[143] Recommendation 6.15 asks that the furnishing of such Training Division analyses to the Review Level Committee be made standard practice.

[144] At the other end of the spectrum, one report was significantly delayed, not having been written until 14 months after the incident.

Recommendation 6.5: The PPB should ensure that after action reports rely on the facts developed by the investigation of the incident (unless the unit shows that those facts are erroneous or incomplete), and that copies are distributed to the detectives who investigated the incidents and their commanding officer.

Although Section 1010.10 sets forth the necessary contents of post-investigation memoranda, most reports failed to include all the elements required by the policy. While all the reports did contain a narrative of the incident, the degree of detail varied widely. In one case, a memorandum failed to make any mention of a second suspect whose presence was of critical relevance to tactics used by the involved officer. In another, no information was provided to explain an officer's use of a firearm, nor did the report indicate which of the two officers present had discharged a weapon.

Many reports did not seek to draw lessons from the shooting incidents. Many did not comment on tactics, even when they were questionable. It was not unusual for the author of the report to state that she or he had no recommendations concerning policy, procedure, or training. In light of the multiplicity of decisions made by officers during the course of a shooting incident, the thoughtful drafter of an after action report should be able to identify some policy, procedure, or training issue worth commenting on.[145]

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.

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[145] Such commentary need not refer only to the need for changes in existing practices. It is equally valuable to document the efficacy of current policy and practice.

III. Review Level Committee

A. Committee Membership and Duties

The Bureau's policy from May, 1998 until the present provides that the voting members of the Review Level Committee are the Assistant Chiefs[146] and the unit commander of the involved member. Non-voting members include the head of the Personnel Division, who acts as facilitator for the committee; a staff member from Personnel; the commanding officer of Internals Affairs;[147] a deputy city attorney; and, optionally, supervisors of the involved member.[148] According to policy, the committee is to meet weekly; in fact, scheduling conflicts preclude such frequent meetings. The policy also provides:

> The Review Level Committee will review the supervisory recommendation as to whether the use of force was accidental, justified or not justified. The involved member's [Assistant Chief] will create and forward a summary and recommendation report to the Chief. Action to be taken beyond the written report to the Chief will be determined on a case-by-case basis.
>
> … The written report to the Chief will be limited to a summary and a recommendation of the finding, but the committee will also examine the following factors as they apply to each incident:
>
> a) Policy
> b) Training
> c) Supervision

[146] During the time period we reviewed there were three Assistant Chiefs. From late 2000 to mid-2003 there were four Assistant Chiefs. The fourth position has now been eliminated. If an Assistant Chief is unable to attend a Review Level meeting, a designated alternate attends in the Assistant Chief's stead.

[147] While the Captain of the Internal Affairs Division is present during the Review Level Committee meetings on disciplinary matters, the last two commanding officers of the Division have not attended discussions of officer-involved shootings. Part of the reason for that nonattendance is that, for at least six years prior to 2003, no officer-involved shooting incident was investigated by IA. One case was referred to IA as a result of a complaint by the suspect after his conviction. IA declined to investigate that complaint as being without merit.

[148] The commanding officer, or other representative, of the Training Division, while not listed in Section 1010.10, also attends committee meetings as a non-voting member.

d) Tactics

e) Equipment[149]

The policy in effect from January, 1997 to May, 1998 was similar, but did not provide for non-voting members. It also provided for membership by what in 1993 was one Assistant Chief and three Deputy Chiefs. The remainder of the substance was the same as the policy that became effective in 1998, although the wording was sometimes slightly different.[150]

The PPB's policy regarding committee composition generally fits within the mainstream of contemporary policing. Because officer-involved shooting and in-custody death incidents involve so many critical issues, it is not uncommon to have them reviewed by a group of senior executives, as the PPB has done. It is also important to include a broad cross-section of the agency to ensure cases are viewed from multiple perspectives, and the PPB's policy does provide for some diversity of viewpoints.

We recommend, however, some modifications in the membership of the committee. First, the unit commander of the involved officer should become a non-voting member of the committee. Second, a civilian from outside the PPB should be made a voting member. Third, both the head of the unit conducting the administrative investigation of deadly force and in-custody death cases and the commanding officer of the Training Division should be added to the Review Level Committee as non-voting members.

While the unit commander of the involved member should continue to attend the Review Level Committee, and participate in the discussion, the unit commander should become a non-voting, rather than a voting member of the committee. The unit commander drafts the after action report, looking at the incident from the perspective of

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[149] PPB Manual § 1010.10 at 409-10, ¶ g (2002).

[150] General Order 1010.10, Appendix A, at 4 (September 13, 1993).

the manager of the unit involved. That allows the unit commander to take the lead in setting the agenda of topics that will be considered in the review process.[151] Among other things, the unit commander is supposed to make conclusions about whether the incident was within policy and is also supposed to make recommendations as to policy, procedure and training. Since part of the role of the Review Level Committee is to review the unit commander's after action report and the actions of members of that unit, it is inadvisable for the manager whose unit's activities are under review to be given a vote on the review panel. Including the commander whose unit's actions are under review is structurally flawed and cannot help but give the appearance of a process that is inequitable.

Recommendation 6.7: The PPB should revise Section 1010.10 to make the unit commander a non-voting member of the Review Level Committee when it reviews officer-involved shootings, other deadly force cases, and in-custody death incidents.[152]

Beside the three Assistant Chiefs, there are significant advantages to adding a civilian from outside the Bureau as the fourth voting member of the committee. A civilian voting member would help ensure that the committee maximizes its potential, both in creating accountability and in learning lessons, and would increase public confidence in the PPB's internal review process. Civilians serve on equivalent type boards in other jurisdictions.[153] For example, in Phoenix, the Police Department's Use-

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[151] One senior officer characterized some unit commanders' presentations as acting like a lawyer for the officer.

[152] The Review Level Committee also considers disciplinary matters that have been investigated by Internal Affairs. Since the unit commander is playing a fundamentally different role in such cases — a role that does not present the same inherent conflicts of interest — there remain good reasons for allowing the unit commander to remain a voting member of the committee on such cases. We thus limit this recommendation to the types of cases that are the subject of this study, as well as other deadly force cases, which raise the same considerations.

[153] To its credit, the Bureau has already convened a multidisciplinary team to look at a 2003 officer-involved shooting, so the Bureau has already started on its own initiative to move in the direction we recommend. The Bureau has also employed multidisciplinary teams, with some members of the team from outside the Bureau, in some of its decision-making processes in recent internal investigations.

of-Force Review Board has *three* citizens among its six members.[154] For another example, in San Jose, the Independent Police Auditor is a member of the panel that reviews all officer-involved shootings.[155]

During the period under review the PPB has not conducted its reviews of officer-involved shootings and in-custody deaths in a way likely to inspire public confidence and community trust. Including a respected, independent outsider would increase the likelihood that the committee would hold officers and their supervisors accountable, when appropriate. A civilian would bring a broader perspective and a heightened sense of the community's sensibilities. Moreover, because the civilian would not have a personal stake in the PPB's internal culture, he or she would have more latitude to provide full and frank criticism where such candor is needed. When combined with the greater transparency and accountability we recommend elsewhere in this chapter, this change in the committee membership would provide a basis for renewed public confidence and community trust. Experience shows that improved police-community relations often stem from more open, collaborative engagements between law enforcement and the public or their representatives.

Because of the nature of the committee and its work, the member from outside the Bureau should have a legal, law enforcement or other relevant professional background, and the sophistication, experience, independence, strength, judgment, credibility, and understanding of the need for absolute confidentiality that would be required to be an effective member of the Review Level Committee. The civilian member would also have to be able to make a substantial time commitment to the post. With respect to the manner of selection, the need for independence requires that the person or persons selecting this civilian be outside the Bureau.

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[154] Phoenix PD Operations Order 3.18, at 8-9 (Feb. 2003). The Use-of-Force Review Board conducts inquiries into police shootings and use of force incidents, determines whether uses of force are within policy, and makes policy recommendations.

[155] See San Jose Independent Police Auditor, 2002 Year End Report, at 45-46 (2003).

Recommendation 6.8: A civilian from outside the Bureau should be made a voting member of the Review Level Committee. The outside committee member should be chosen in a manner decided by the City's elected officials.

The PPB should also change its policies to ensure that the head of the unit tasked with conducting the administrative investigations of deadly force and in-custody death cases serves as a non-voting member of the Review Level Committee.[156] If the PPB decides to follow the Internal Affairs Overlay Model of investigations we recommended in Chapter 4, then it will already be in compliance with this recommendation, as the commanding officer of Internal Affairs already occupies a non-voting seat on the Review Level Committee. If, however, the PPB elects to follow the Specialist Team Model described in Chapter 4, [157] then the PPB should revise its policies to provide the commander of that team with a non-voting seat on the Review Level Committee. Just as it makes sense to have the commanding officer of the involved member presenting that unit's view of the incident, it likewise is important to have the commanding officer of the unit that investigated the incident present the results of the administrative investigation. This way the unit commander who conducted the first level of review, and the commanding officer of the unit that performed the investigation that will inform the second level of review, will both be able to present their perspectives on an equal footing — as non-voting members of the committee.

In a similar vein, the PPB should also make the commanding officer of the Training Division a non-voting member of the committee. The Training Division has a focused perspective on the tactics that an officer should have employed, and Training is the key unit in the information feedback loop. The PPB acknowledges the importance of this insight, as the commander of the Training Division currently attends each Review Level Committee meeting to evaluate deadly force and in-custody death cases. By

[156] Recommendation 4.1 calls for replacing the PPB's current Homicide-only model of investigating officer-involved shootings and in-custody death cases with one of two broader, multidisciplinary approaches — either the Internal Affairs Overlay Model or the Specialist Team Model.

[157] See Chapter 4, Part II.A.1.

formally elevating the commander from his or her current role as invitee to a position on the Review Level Committee itself, the PPB will make explicit the importance of that commander's role in the process.

Recommendation 6.9: The PPB should amend its policy and its practice to make the commanding officer of the unit conducting administrative investigations of officer-involved shootings and in-custody deaths, and the commanding officer of the Training Division, non-voting members of the Review Level Committee.

B. Meeting Procedures

Our review of the 34 officer-involved shooting and in-custody death incidents between January 1997 and June 2000 showed that only 18 of the 34 cases were considered by the Review Level Committee.[158] Of the 16 cases that were not considered, two — the two shootings by deputies from the Sheriff's departments of other counties that occurred in Portland — were appropriately not considered as no PPB officer fired shots in those incidents. Thus, 44 percent, or 14, of the 32 cases that should have been considered by the Review Level Committee, pursuant to Manual Section 1010.10,[159] were not placed on the committee's agenda. That almost half the cases that should have been considered were not, suggests that Review Level consideration of these cases was not a high priority for the Bureau in the period under review.

Some of the 14 cases that were not reviewed by the Review Level Committee were subjected to other *ad hoc* internal review procedures and some were not reviewed at all. An Assistant Chief in the 1997-2000 time period recalled that the two incidents in

[158] The period from the date of the incident until the date the Chief signed the "justified" determination usually ranged from six weeks to six months, but one case among the 18 was not concluded until a year after the incident. In the seven cases where we were provided with voting logs, we can determine that the Chief's acceptance of the recommendation came between six days and one month after the Committee's recommendation was made.

[159] As noted in connection with our discussion concerning Recommendation 6.1, although Section 1010.10 is not entirely clear that all in-custody death incidents should be presented to the committee, the PPB command staff agrees that all such cases should be presented.

which officers had been killed were subjected to an accelerated review process led by the then-Chief. The Assistant Chief likewise recalled that the two in-custody deaths, both in 1998, were also the subject of an *ad hoc* review process. The former Assistant Chief believes that no paperwork was generated in connection with any of these reviews done outside the Review Level Committee process.[160] Cases where the shooting involved the Special Emergency Reaction Team (SERT) were apparently subject to a SERT internal review, which was seen as exempting SERT cases from Review Level.

In addition to the cases that were subjected to *ad hoc*, but undocumented, review procedures, others of the 14 cases apparently slipped through the cracks because of the absence of a tracking system.[161] As noted in connection with our earlier discussion of cases in which no after action report had been completed, there was a direct connection between the absence of an after action report and the absence of Review Level consideration. The reason is that what generally triggered placing a case on the Review Level Committee's agenda was the arrival of the after action report at an Assistant Chief's office. In fact, only two of the 14 cases not presented to the Review Level had after action reports prepared. And none of the 12 cases without after action reports was presented to Review Level.

Recommendation 6.10: All officer-involved shooting and in-custody death incidents should be presented to the Review Level Committee. The PPB should develop a tracking system to ensure that all such incidents are presented.[162]

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[160] None of the files provided us by the PPB concerning these 14 cases contained any documents relating to, or even referring to, an informal review process.

[161] As of May, 2003 the PPB had not created a tracking system for officer-involved shooting and in-custody death cases to ensure that they were presented to the Review Level Committee. Early in 2003 the Personnel Division identified and calendared a case for committee consideration that had originally been overlooked for placement on the committee agenda.

[162] As of May, 2003 the PPB had not created a tracking system for officer-involved shooting and in-custody death cases to ensure that they were presented to the Review Level Committee. The Personnel Division had recently (as of this spring) identified and calendared a case for committee consideration that had originally been overlooked for placement on the committee agenda.

It is essential that the Review Level Committee begin to issue written findings. During 1997-2000, and at present, Section 1010.10 expressly limited the report issued by the Review Level Committee at the conclusion of its consideration of a case to "a summary and a recommendation of the finding."[163] "The summary and recommendation of the finding" during 1997-2000 read as follows:

> On [date], the Review Level Committee convened regarding the above Officer involved Use of Deadly Physical Force. The Review Level Committee consisting of [names of voting members] and myself unanimously recommend a "Justified" finding on this matter.

The form then provided alternative dated signature lines for the Chief. The first said "Concur With Finding" and the other said: "Disagree With Finding." The only other written document generated as part of the review level process was a log that showed how each of the voting members voted as to each allegation.[164]

Written findings would be an improvement for several reasons. At present the Chief receives a two-sentence conclusion from the review panel, with no statement of the reasons for that conclusion or the analysis that led to that conclusion. If provided with that analysis, the Chief would have more information upon which to make the ultimate determination about the case under review. Second, a self-regulating system needs transparency so that outsiders (and those in the Bureau who are not directly involved in the review process) can determine what is happening, and decide whether or not they have confidence in the result and in the process. Third, written findings also create a historical record, both at

[163] PPB Manual § 1010.10 at 410, ¶ g(4) (2002).

[164] Because there is no written documentation of what was discussed during the Review Level consideration of the 18 cases that did go before the committee, we have no way of judging the quality and completeness of the discussion and analysis of these cases by the members of the committee.

the time of the findings years later, if it becomes relevant to determine what happened on a particular case or group of cases. Fourth, the knowledge that others will be able to read the committee's findings helps give structure to committee deliberations and fosters accountability. Finally, the Bureau's capacity to respond to the lessons identified in the review process is severely hampered if there is not an adequate record of the concerns of the committee on that score.

Recommendation 6.11: PPB policy should be amended to require that full written findings be provided to the Chief to explain and document each Review Level Committee determination on officer-involved shooting and in-custody death cases.

The argument against written findings, most particularly written findings that are critical of officer conduct, stems from a fear that they will make civil lawsuits more difficult to defend and increase the amount of money paid out in civil judgments and settlements.

Although the PPB and the City could possibly encounter such difficulties in the short-term, there are four reasons to believe that they, along with the community they serve, would benefit in the long-term. First, if the PPB is to reduce risk over the long-term, it must critique its current practices in a full, unfettered manner by means of thorough investigations and rigorous review that, over time, will allow managers to identify systemic problems and correct them. Fully documenting the PPB's own internal analyses of critical cases not only provides a basis for future learning, but also increases the likelihood that similar cases will be evaluated in a consistent manner. As it stands today, the PPB has no way of evaluating the cases of today by looking back at how similar cases were evaluated in the past. Fully documenting the Review Level Committee's analysis would thus not only assist the PPB in staying on mission, but give the officers under evaluation further assurance that they are being evaluated in a consistent manner.

Second, the PPB, in theory at least, already embraces this view when it comes to after action reports. PPB policy requires unit commanders to provide a detailed, candid assessment of officers' performance in writing. Because these written assessments may be discovered in subsequent litigation, the PPB has already implicitly (and properly) taken the view that written analyses are valuable, despite any short-term litigation consequences. There is no reason to believe that documenting the Review Level Committee's own analysis would have any additional negative effect on civil litigation.

Third, other agencies' predictions of long-term harm have not come to fruition. For example, the experience with the Los Angeles County Sheriff's Department over the past decade has been that a vigorous, well-documented risk management approach to critical incidents actually works to *decrease* litigation exposure: While the County of Los Angeles paid out $17 million in force-related judgments and settlements in 1995-96, it paid out only $6 million for such judgments and settlements in 2001-02.[165]

Finally, better documentation of the review process serves to improve a law enforcement agency's standing with the community it serves. Fully documenting its Review Level Committee's analysis is an important step toward demonstrating to the Portland community that the PPB can police itself and will act with integrity, fairness, and openness in responding to misconduct or substandard performance.

A related concern is the apparently longstanding tradition that the Review Level Committee issue only unanimous recommendations to the Chief. Of the 18 cases we reviewed that went to Review Level, the files on seven included the committee voting log. All showed unanimous "justified" findings. So did the Chief's findings in the other

[165] Special Counsel Merrick J. Bobb and PARC, *16th Semiannual Report on the Los Angeles County Sheriff's Department*, at 109 (2003).

11 cases. Moreover, no one we spoke to at the PPB is aware of any officer-involved shooting case or in-custody death incident (that was considered by Review Level) that did not result in a unanimous "justified" finding. On the other hand, the apparent expectation of unanimity does not extend to the discipline cases considered by the Review Level Committee. While we did not review any of those cases, we were told that dissents on those cases are not unusual. An expectation of unanimity undermines the integrity and the credibility of the process.

Recommendation 6.12: The PPB should develop procedures for the Review Level Committee that require members to vote based on their best judgment of the relevant facts and circumstances and that encourage dissent when appropriate.[166]

During the 1997-2000 period, and at present, the unit commander of the involved officer or officers opens the consideration of a case by orally presenting the facts of the case and the issues perceived. Except in high-profile cases, neither the detectives who investigated an officer-involved shooting or an in-custody death, nor the commanding officer of the Detective Division were invited to Review Level consideration of the cases they investigated. This omission deprived the committee of valuable information and compounded the problem observed in the after action reports, where little reference was made to the results of the investigative work. Since the investigators arguably had both the most complete and the most objective information, the non-inclusion of the investigators and their commanding officer limited and in some cases could have distorted the information available to the committee.

Under the procedures of the Los Angeles County Sheriff's Department, and the Los Angeles, Philadelphia, San Jose, and Phoenix police departments, to name a few, the investigators are the ones who present the case, highlighting key statements, inconsistencies, and issues. The rationale is that the investigators know the case better than anyone else. They also are less likely to be advocates for the involved officer — an

issue we noted earlier had been reported to us. The PPB should adopt this best practice when it switches to a multidisciplinary approach of conducting administrative investigations.

Some within the PPB have argued that requiring the unit commander to present the case is desirable because it ensures that the unit commander will have a complete grasp of the case. As one top official observed, "When that commander is sitting there [at the Review Level Committee meeting], he . . .better know the case inside and out." While we certainly agree that the unit commander must master all of the salient aspects of a given case, there is no reason to believe that the only way to ensure such mastery is to require him or her to present the case to the Review Level Committee. Instead, merely requiring the unit commander to attend the Review Level Committee meeting should serve as a sufficient incentive. Indeed, members of our staff have sat in on dozens of deadly force reviews conducted by other agencies where the concerned unit commander was in attendance but did not present the case to the committee. In virtually every case, the review panel asked the unit commander about some aspect of the case, and the commander was ready with a detailed response. We see no reason why PPB unit commanders could not arrive at Review Level Committee meetings similarly prepared.

Recommendation 6.13: The investigators who conduct the administrative investigations should take the lead in presenting officer-involved shooting and in-custody death cases to the Review Level Committee.

As is discussed in Part II of Chapter 5, the file that Homicide presented to the Review Level Committee did not include audio and videotapes, photographs or other items that had not been included in the official investigative file. Since the investigators themselves were not appearing before Review Level, the Committee's members were deprived of a great deal of pertinent and revealing information. Tapes or photographs often present the most compelling or determinative evidence. The five law enforcement

[166] The Chief, who was formerly a senior officer with the LAPD, informed us that he often found the dissents included in the findings of LAPD shooting review boards to be helpful.

agencies we cited in the previous paragraph all have their investigators present their review boards with whatever evidence is relevant and useful — regardless of the form it takes. The PPB should adopt a similar practice.

Recommendation 6.14: The administrative investigators should present a complete file — regardless of the form of the evidence, and specifically including video and audiotapes and photographs — to committee members in advance of the committee meeting, and should likewise present all evidence they deem pertinent to the Review Level meeting, regardless of the form that evidence takes.

C. Committee Analysis and Determination

Earlier in this chapter in our discussion of after-action reports, we noted an example of excellent quality work involving a case where a sergeant in the Training Division read the file that was being presented to the Review Level Committee and wrote a memo before the meeting, discussing the involved officer's judgment and tactics, particularly as they related to the Bureau's training. For instance, in his memo, which was addressed to the commanding officer of the Training Division, the sergeant wrote that the involved officer had made "a serious error in judgment in doing a single person clear of a residence." He continued, "The Training Division does not teach one person clearing. Building clears are always done with a minimum of two officers." The sergeant went on to discuss two other tactical errors by the involved officer that jeopardized the safety of the victim. We do not know whether the captain of the Training Division circulated the sergeant's memo to others attending the Review Level meeting considering the case in question, but certainly having access to that analysis and information would have been helpful to other members and would have focused them on the tactical and training issues involved in the incident. Given the benefits to the Review Level Committee members of an analysis by the Training Division, we recommend that such a practice be made standard.[167]

Recommendation 6.15: Before a meeting of the Review Level Committee on an officer-involved shooting case or an in-custody death incident, the Training Division should prepare a written analysis of the tactical and training issues involved and circulate that analysis to committee members in advance of the meeting.

Manual Section 1010.10 allows the Review Level Committee to make only one of three recommendations about the use of deadly force they are considering: "accidental, justified or not justified."[168] The problem with this limited range of options is that it does not leave any room for the tactical considerations, which are the issues most often raised by the use of deadly force. Having a range of options improves the usefulness of the determination for those to whom these determinations matter. It would also require the panel to make more precise, nuanced decisions, and requires the board to consider and resolve issues that might otherwise not be addressed.[169] Best practice requires that review panels have a range of options, including one that addresses concerns when they are solely tactical.

Pursuant to a settlement agreement with the U.S. Department of Justice, the Metropolitan Police Department in Washington, D.C. revised its list of potential findings in use of force cases to include comments on tactical performance. The potential findings are as follows:

> **Justified, Within Departmental Policy** — this classification reflects a finding in which a police use of force is determined to be justified, and

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[167] To facilitate the ability of the Training Division to produce its memo in a timely fashion that does not delay Review Level consideration of a case, a copy of the file on the administrative investigation should be sent to the Training Division when it has been completed (rather than waiting until the Review Level meeting has been scheduled). Such a practice would also emphasize the importance of the information feedback loop that we discuss later in this chapter.

[168] PPB Manual § 1010.10 at 409, ¶ g(3) (2002).

[169] We cannot determine the degree to which the Review Level Committee addressed tactical and training issues in the 18 cases we reviewed, as there is no documentation of what the committee discussed.

during the course of the incident the subject officer did not violate department policy.

Justified, Policy Violation — this classification reflects a finding in which a police use of force is determined to be justified, but during the course of the incident the subject officer violated a department policy.

Justified, Tactical Improvement Opportunity — this classification reflects a finding in which a police use of force is determined to be justified, and during the course of the incident no departmental violations occurred. However, the investigation revealed tactical errors that could be addressed through non-disciplinary and tactical improvement endeavors.

Not Justified, Not Within Departmental Policy — this classification reflects a finding in which a police use of force is determined to be not justified, and during the course of the incident the subject officer violated a department policy.[170]

Such a range of options, if adopted by the PPB, would improve discussions and decision-making at the Review Level Committee, by focusing attention on the different levels of review: legal, policy, and tactical.

Recommendation 6.16: The PPB should amend its policy to increase the options the Review Level Committee has for outcome determinations so that those options cover the different levels of review: legal, policy and tactical.

The Review Level Committee also must be able to gather evidence, order further investigations, and expand the body of information available to it, if necessary. A credible review board cannot make determinations without having access to all the

[170] Metropolitan Police Department General Order 901.08, Use of Force Investigations at 14 (October 2002). A complete copy of this order is set forth in the Appendix at page 132.

necessary evidence. Under its present format the Review Level Committee has the power to request Homicide to investigate further, but the committee does not exercise that power. Among the cases we examined, the Review Level Committee was frequently presented with inadequate factual records (see discussion in Part II of Chapter 5). Nonetheless, the committee made its determinations despite the missing evidence. If our recommendation for a multidisciplinary administrative investigation is adopted (see Recommendation 4.1), the need for additional evidence should significantly diminish. Nonetheless, any competent fact-finding board must have a mechanism to gather additional evidence if it finds it lacking.

Recommendation 6.17: The Review Level Committee should seek to obtain additional information whenever the committee determines that such information would assist it in fulfilling its responsibilities.

D. Information Feedback

One of the central purposes of internal review is to apply lessons learned so as to replicate successes and avoid failures in the future. In the context of officer-involved shootings and in-custody deaths, such analyses principally seek to identify means to reduce officers' future exposure to danger and to determine whether, consistent with officer safety, less force could be used in similar incidents in the future. The focus then is on safety, protection, and preservation of life. Manual Section 1010.10 appropriately charges the Review Level Committee with examining the policy, training, supervision, tactics, and equipment implications of the incidents that it reviews.[171] The charge, and the list of factors, are appropriate.

The lack of documentation hinders our ability to assess whether the committee appropriately fulfilled the Manual's charge to consider the policy, training, supervision, tactics and equipment implications of the 18 cases that we reviewed where there was

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[171] PPB Manual § 1010.10 at 410, ¶ g(4) (2002).

Review Level consideration. We do, however, have limited anecdotal evidence both from cases during the period of time we reviewed and from follow-up relating to cases that were outside the scope of our review.

As a result of the informal review led by the then-Chief of an officer-involved shooting incident that led to an officer's death, the PPB changed it ballistic armor requirements to rule out V-necked vests, as that was the place of entry of the fatal bullet. As a result of an informal review of an in-custody death, the Bureau resumed training officers in CPR resuscitation. As a result of two or three cases where shootings occurred after officers inadvisably reached into a suspect's car, the Training Division was asked to address the topic at in-service training. These responses are good examples of the Bureau trying to learn the appropriate lessons from past problems.

An effort to track the follow-up on issues that were raised at Review Level was begun by the PPB in March 2001 and discontinued in March 2002.[172] The intent of this exercise was to ensure that recommendations made by the committee were in fact being complied with. Most of the recommendations — 11.5[173] of 15 — were made to the Training Division. Although the Personnel Division tracked the recommendations for the year-long period, it did not determine whether 13 of the 15 recommendations had been complied with until we asked Personnel to do so. The results were positive. Eight of the 15 recommendations had been complied with, three had been partially complied with, three had not been complied with, and the result of the final recommendation was unknown. For the six recommendations that apparently emanated from officer-involved shooting cases, there was compliance in four instances and partial compliance in the other

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[172] With respect to these 2001-02 cases, we have not reviewed those cases and are not familiar with them. We are thus unable to comment on the appropriateness or completeness of the recommendations by the Review Level Committee. We can report solely on how well the Bureau informed us that it followed up on those recommendations. Also, of the 14 cases, only five appear to be officer-involved shooting cases and none, in-custody deaths.

[173] One of the recommendations was made jointly to Training and another unit; thus the "half recommendation."

two. Tracking these recommendations was a positive innovation that should be made permanent by the Bureau.

Recommendation 6.18: The PPB should create systems that ensure that all lessons learned — both successes and failures — are systematically identified and followed up on.

IV. Awards

Officers involved in 13 of the 30 PPB officer-involved shootings we examined were nominated for awards.[174] Manual Section 210.90 provides: "All community and Bureau members are encouraged to report acts of exemplary service to the community or Bureau that are deserving of recognition." An Award Review Committee, composed of 15 to 17 voting members, all from the Bureau except for one to three members from the community, votes for or against nominations, or to modify the nomination as to the award being considered. Those votes serve as nominations to the Chief who makes the final decision on awards.[175]

We looked at the award process only insofar as it relates, or should related, to the review process.[176] Both the review process and the award process look retrospectively at events and make judgments about what occurred. Review seeks to foster accountability and identify lessons learned. Awards seek to reward for exemplary behavior. Because meaningful review requires an evaluation of the strengths and weaknesses of an officer's performance, the judgments that must be made in each process are similar in nature, even

[174] Officers in eight of the 11 shootings that occurred between June, 1999 and May, 2000 were nominated for awards, while officers in only five of the 19 shootings between January, 1997 and March, 1999 were nominated.

[175] PPB Manual § 210.90 at 36-37 (2002). The policy provides that the committee facilitator can appoint two temporary members, who can be either from the Bureau or the community, to satisfy the committee's quorum requirements. Excluding those temporary appointments, the committee has 15 members, one of whom is from the community.

[176] We did not seek to determine whether awards should or should not have been made. We express no opinion on that topic.

if different in purpose. Insofar as the Bureau's interests are implicated by the intersection of these related analyses, the Bureau should want to avoid having an officer who was criticized in the review process be rewarded for dubious conduct, and ensure that officers who exhibited exemplary behavior are recognized. Secondly, the Bureau should want to refer back to the Review Level Committee for possible further analysis any new information that surfaces in the award process.

A case we reviewed implicated both those interests. An officer responded to the scene of a domestic dispute, where the man was inside the apartment alone. The officer sought permission to forcibly enter the dwelling to arrest the man for menacing. There were conflicting accounts regarding whether the sergeant authorized entry. The officer in fact kicked the door in, confronted the man who had a machete, and shot him.

Homicide did not interview the sergeant as part of its investigation, leaving the file murky as to whether the sergeant authorized a forcible entry. The Review Level Committee did not consider this case. Fourteen months later, the officer was being considered for an award arising out of this incident. Two police commanders opposed the award on the ground that the officer had violated the sergeant's directive to wait to enter the apartment. One wrote, in part:

> Besides the issue of not following the sergeant's direction, [the officer's] actions created the circumstances that led to a deadly force situation and receiving a Police Medal would reward him for violating procedures.

There is no indication that the Award Review Committee made that information known to the Review Level Committee so that it might choose to examine the case that it had initially overlooked. The award, however, was denied.

In the case discussed we do not know what circumstances led the Award Committee to seek the commanders' information. We do know, however, that Manual

Section 210.90 limits the files that the committee facilitator must check to "personnel files and IAD files when that information applies to the case under review."[177] No procedure exists for checking the investigative file on the shooting, or for checking with the Review Level Committee for information that it might have that was relevant to the granting of an award.

In light of the fact that the Bureau has established a unit-level and an executive-level review of officer-involved shootings, it seems prudent that the results of those reviews be consulted before a decision is made concerning an award nomination. Likewise, it seems desirable that any information the Award Committee receives that would be relevant to the review process should be referred to the Review Level Committee so that it can determine whether further investigation or review is necessary.

Recommendation 6.19: The PPB should revise its awards policy and procedures in officer-involved shooting and in-custody death cases to ensure that the Award Review Committee and the Chief are aware of all facts and circumstances relevant to the appropriateness of an award that were revealed in the investigation of the incident, in the after action report, and in the Review Level Committee proceedings.

Recommendation 6.20: The PPB should revise its awards and Review Level policy and procedures in officer-involved shooting and in-custody death cases to require that the Awards Review Committee facilitator advise the Review Level Committee in writing of any information revealed in the awards process that was not in the investigative file, the after action report, or the Review Level Committee's records. Upon receipt of notice of such new information, the Review Level Committee should consider whether to reopen its review of the incident, with or without further administrative investigation.

[177] PPB Manual § 210.90 at 41 (2002).

V. Recommendations

Recommendation 6.1: The PPB's policies relating to reviews of deadly physical force — both after action reports and Review Level Committee — should be explicitly extended to in-custody death incidents.

Recommendation 6.2: The PPB should ensure that after action reports are completed in all officer-involved shooting and in-custody death cases, and that unit commanders are held accountable if the reports are not completed in a timely fashion.

Recommendation 6.3: The PPB should enforce its policy that requires unit commanders, rather than their subordinates, to prepare and sign after action reports in deadly force cases.

Recommendation 6.4: The PPB should create a model after action report — from an actual or a hypothetical case — to demonstrate to unit commanders both the form and type of analysis that such reports should employ.

Recommendation 6.5: The PPB should ensure that after action reports rely on the facts developed by the investigation of the incident (unless the unit shows that those facts are erroneous or incomplete), and that copies are distributed to the detectives who investigated the incidents and their commanding officer.

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.

Recommendation 6.7: The PPB should revise Section 1010.10 to make the unit commander a non-voting member of the Review Level Committee when it reviews officer-involved shootings, other deadly force cases, and in-custody death incidents.

Recommendation 6.8: A civilian from outside the Bureau should be made a voting member of the Review Level Committee. The outside committee member should be chosen in a manner decided by the City's elected officials.

Recommendation 6.9: The PPB should amend its policy and its practice to make the commanding officer of the unit conducting administrative investigations of officer-involved shootings and in-custody deaths, and the commanding officer of the Training Division, non-voting members of the Review Level Committee.

Recommendation 6.10: All officer-involved shooting and in-custody death incidents should be presented to the Review Level Committee. The PPB should develop a tracking system to ensure that all such incidents are presented.

Recommendation 6.11: PPB policy should be amended to require that full written findings be provided to the Chief to explain and document each Review Level Committee determination on officer-involved shooting and in-custody death cases.

Recommendation 6.12: The PPB should develop procedures for the Review Level Committee that require members to vote based on their best judgment of the relevant facts and circumstances and that encourage dissent when appropriate.

Recommendation 6.13: The investigators who conduct the administrative investigations should take the lead in presenting officer-involved shooting and in-custody death cases to the Review Level Committee.

Recommendation 6.14: The administrative investigators should present a complete file — regardless of the form of the evidence, and specifically including video and audiotapes and photographs — to committee members in advance of the committee meeting, and should likewise present all evidence they deem pertinent to the Review Level meeting, regardless of the form that evidence takes.

Recommendation 6.15: Before a meeting of the Review Level Committee on an officer-involved shooting case or an in-custody death incident, the Training Division should prepare a written analysis of the tactical and training issues involved and circulate that analysis to committee members in advance of the meeting.

Recommendation 6.16: The PPB should amend its policy to increase the options the Review Level Committee has for outcome determinations so that those options cover the different levels of review: legal, policy and tactical.

Recommendation 6.17: The Review Level Committee should seek to obtain additional information whenever the committee determines that such information would assist it in fulfilling its responsibilities.

Recommendation 6.18: The PPB should create systems that ensure that all lessons learned — both successes and failures — are systematically identified and followed up on.

Recommendation 6.19: The PPB should revise its awards policy and procedures in officer-involved shooting and in-custody death cases to ensure that the Award Review Committee and the Chief are aware of all facts and circumstances relevant to the appropriateness of an award that were revealed in the investigation of the incident, in the after action report, and in the Review Level Committee proceedings.

Recommendation 6.20: The PPB should revise its awards and Review Level policy and procedures in officer-involved shooting and in-custody death cases to require

that the Awards Review Committee facilitator advise the Review Level Committee in writing of any information revealed in the awards review process that was not in the investigative file, the after action report, or the Review Level Committee's records. Upon receipt of notice of such new information, the Review Level Committee should consider whether to reopen its review of the incident, with or without further administrative investigation.

7. Incident Reviews: Risk Management Issues

Police work is inherently dangerous. Dangerous situations that threaten officers' lives or the lives of others are interspersed among countless day-to-day interactions with the law-abiding public and with lawbreakers who pose no threat. In some of those dangerous situations officers will have no good option but to use deadly force. The risks arising from police operations are not, however, entirely unpredictable or random. Although officer endangerment, officer-involved shootings, and in-custody deaths may, to some degree, be inherent to policing, careful risk management will minimize the frequency with which they occur.

As discussed in Chapter 1 of this report, PARC conducted a detailed review of 32 PPB 1997-2000 incidents that involved either an officer-involved shooting or an in-custody death.[178] In doing so, we identified five areas where the PPB could improve the handling of risk:

1. Critical Incident Management
2. Field Tactics
3. Shooting at Moving Vehicles
4. Equipment Issues
5. Police Encounters with Individuals with Mental Illness

In each instance where the PPB's risk management fell below a level of best practice, the chances of an officer or civilian suffering harm increased. This does not mean that lapses in risk management led to injuries or deaths to officers, shootings by officers, or in-custody deaths that *would* otherwise have been avoided; so many variables affect the outcome of policing scenarios that such judgments typically cannot be made with any degree of certainty: Would a gun-toting subject who was confronted and shot in

[178] The purpose of our review of the two additional shootings by other jurisdictions' law enforcement agencies within the city limits of Portland was solely to consider issues relating to the quality of the PPB's investigation of those cases.

a poorly-managed police operation have forced officers to shoot him even if a well-managed strategy had been employed? Would a knife-wielding subject who was shot with a gun have been effectively subdued if a less-lethal weapon had been deployed? In most cases, one can only speculate as to the answers to such questions.

Lapses in risk management do, however, raise the question of whether a more favorable incident outcome *could* have been achieved. Although it may not be possible to say, case-by-case, whether death or injury to an officer or a civilian was truly avoidable, it is undoubtedly the case that sometimes the answer to that question will be "yes." Deficiencies in risk management, therefore, invite avoidable trauma, pain, and grief for officers and civilians alike.

The following discussion covers the risk management concerns our review identified, as well as noting some of the PPB's strengths revealed by our review process. Recommendations are prompted by the empirical evidence our case reviews provided.

Some of our recommendations, such as those relating to basic tactical errors or planning issues, necessarily omit specifying the *action* the PPB should take. Instead, they identify *goals*, leaving the logistics by which those goals might be attained to the judgment of the Bureau. These goal-oriented recommendations all relate to the PPB's need to more consistently exercise professional policing skills that many of its personnel already possess. Thus, it is not the case that the Bureau needs to be told *how* a particular aspect of police work should be performed, but rather that it needs to focus greater attention on ensuring that its operations are consistently performed in accordance with best practice. The steps the Bureau needs to take to achieve the goals we identify will typically involve adjusting training and management practices, combined with an organizational willingness to engage in critical self-assessment.

I. CRITICAL INCIDENT MANAGEMENT

Critical incidents — situations that present the risk of life-threatening danger to police officers or members of the public — demand a skillful, effectively managed police response. An agency that consistently ensures that critical incidents prompt such a response will have gone a long way towards managing the risk they present.

While certain kinds of critical incidents, such as natural disasters or terrorist bombings, are a rare occurrence, others — such as the incidents in the cases we reviewed — constitute a relatively routine feature of police work. Our review of officer-involved shootings revealed that the majority occurred during incidents where PPB personnel had a prior indication that they were responding to a potentially dangerous situation — danger typically stemming from the possession or use of a firearm.

When officers have no option but to react immediately to a rapidly unfolding incident, the potential for a thoroughly managed police response can be limited. Some of the incidents we reviewed involved officers having to make split-second decisions in response to immediate deadly threats.[179] In 18 cases, however, we found that the officers had advance indication that an incident involved substantial risk and thus had time to manage their responses. In 16 of these cases we concluded that the involved officers had, to varying degrees, failed to manage their response effectively. These failures in critical incident management unduly jeopardized the safety of officers, bystanders and suspects.

Consideration of critical incident management issues entails much more than simply questioning whether an officer was justified in pulling the trigger at the moment an encounter with a suspect turned deadly. In order to conduct this aspect of our review

[179] In one case, for instance, two officers approached a pedestrian in order to conduct an investigative stop. The pedestrian produced a handgun and opened fire on the officers, leaving them little option but to immediately return fire. The rapidity with which this incident became "critical" precluded thorough management.

we examined incidents in their entirety, from the moment the Bureau received an indication that something potentially dangerous was unfolding. We then examined 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. We considered the impact of the acts and omissions we identified on the overall operational management of the police response to each incident.

As discussed in Chapter 6 of this report, consideration of incident management practices — coupled with a systematic review process that facilitates a meaningful organizational response to issues as they arise — is essential to the realization of effective policing and the minimization of danger to officers and civilians. In our reviews the degree to which the PPB had documented the incident defined the extent to which we could consider incident management issues. We found that our ability to conduct a fully comprehensive review was often constrained by the limited details documented by investigators. If the PPB is to properly assess its approach to critical incident management in the future, it will need to ensure that the quality and thoroughness of its investigations allow for such assessments. Even with these limitations, our review revealed a number of critical incident management themes — planning, communication, field supervision, and tactics (including high-risk vehicle stops, vehicle pursuits, foot pursuits, use of cover or concealment, crossfires, and bystander endangerment) — each of which the PPB should consider in order to optimize its management of risk.

A. Planning

Planning facilitates police actions that are coordinated, considered and information-based. As such, planning represents an essential component of effective critical incident management. Whenever police officers have the opportunity to formulate a plan before taking action, they should take full advantage and do so effectively. To do otherwise is to virtually guarantee a sub-optimal response to whatever challenges an incident might present.

Our review identified failures to effectively plan as a problematic feature of 11 of the officer-involved shooting incidents we reviewed. These problems are illustrated by the following examples:

1. Gathering necessary intelligence before taking action

- A team of officers forced entry to a house in the course of a pre-planned operation, unaware of critical information about the occupant that was available on law enforcement databases.
- An officer did not await the results of a license plate check before conducting an investigative stop of a vehicle in connection with a shooting incident.

2. Taking account of risk factors

- Officers conducted a building entry without taking account of the presence of a surveillance camera.
- Officers failed to recognize the planned apprehension of a suspect wanted on a $1-million warrant as "high-risk."

3. Assembling sufficient police resources before taking action

- In two cases, officers attempted non-emergency forced entries to buildings with just one officer deployed to cover the four-sided exteriors of the premises.
- A single officer engaged two armed robbery suspects without awaiting back-up.

4. Using available time

- Under non-emergency circumstances, officers attempted to force entry to an apartment containing an armed male without using available time to make basic inquiries or assembling an appropriate team.

- Under non-emergency circumstances, an officer forced entry to a house before back-up (which was en-route) arrived, without using available time to establish whether a forced entry was required or to attempt negotiation with the occupant.[180]

In each instance cited here, better planning could have enhanced officer safety and reduced the likelihood that officers would need to use their weapons in self-defense.

Recommendation 7.1: In order to minimize risk, the PPB must ensure that, whenever feasible, a sound plan is devised before action is taken in critical incident scenarios.[181]

B. Communication

Effective communication is an essential element of any well-managed police operation. Our review identified failures in communication as a problematic incident management feature in 13 cases. Failures in communication preclude effective supervision and coordination of officers' actions, rendering effective overall incident management impossible and producing sub-optimal operational performance. These failures are characterized by the following examples:

[180] Although the PPB did not document the strategic errors apparent in this case in its review of the subsequent officer-involved shooting, a senior officer did identify the issue when he recommended the denial of a commendation for which the involved officer was nominated in connection with the incident. The senior officer wrote: "This act [forcing entry] precipitated the necessity of confronting a suspect in his own house without the benefit of proper support. The officer should have waited for more support and attempted contact by phone or allow a sergeant to determine whether this constituted a SERT callout." This kind of critical analysis — which we seldom saw in the cases we reviewed — should be a standard component of the PPB's shooting review process.

[181] As part of this effort, the PPB should ensure that its internal officer-involved shooting reviews address the issue of planning so that problems can be remedied and successes emulated.

1. Alerting colleagues to danger

- In two cases, officers failed to inform colleagues of their suspicion that a person was armed.
- Officers who pursued a suspect who had fired at them did not inform fellow officers joining the pursuit that a shot had been discharged.

2. Supervisors communicating tactical instructions

- A sergeant did not issue any instructions to a team of officers following a "shots fired" broadcast, choosing instead to simply announce that he was responding to the scene.
- A sergeant monitoring a pursuit of armed suspects issued no tactical instructions, despite the clear failure of the involved officer to use sound tactics.

3. Communicating key tactical decisions

- An officer entered an area under containment without informing other involved personnel that he was doing so.
- Officers failed to communicate at the conclusion of a vehicle pursuit, leading to a situation where groups of officers undertook divergent and incompatible strategies to apprehend the suspect.

4. Effectively coordinating radio traffic

- When Portland officers responded to a call for assistance from a neighboring jurisdiction, several of them switched to a radio channel that would enable them to communicate with that jurisdiction's officers. Other Portland officers continued to use the Portland channel. As a result, critical incident details that were transmitted over just one of the channels were not received by all officers.

Recommendation 7.2: In order to reduce the risk generated by deficiencies in communication, the PPB must take steps to ensure that their occurrence is minimized.

C. Field Supervision

Effective field supervision is essential for the sound management of critical incidents. Effective field supervisors possess a good understanding of operational police tactics and procedures, and use their leadership skills and knowledge to ensure that the officers under their command perform to a high standard. Moreover, an effective field supervisor is alert at all times to his or her officers' activities, and seeks to actively manage the police response to any incident that presents a significant risk to the well-being of officers or civilians, or that requires the coordination of multiple officers' actions.[182]

Our review identified 10 cases where problematic supervisory acts or omissions appeared to have negatively affected the PPB's incident management. Indeed, overall, we would identify supervision failures as a particularly critical weakness in the cases we reviewed. We also reviewed at least one case where the field supervision demonstrated during a critical incident response satisfied a very high standard.

Sound critical incident management can occur only when field supervisors perform their role effectively. The PPB should seek to ensure that all supervisors are equipped with the requisite skills and knowledge to effectively command their officers whenever a critical incident arises. Although the sheer variety of incidents the Bureau faces might rule out the use of a "one-size-fits-all" model of incident management, adherence to some general principles would increase the likelihood that incidents will be better managed by the Police Bureau.

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[182] Inquiry into how the San Jose (CA) Police Department, in a city of 900,000 with more than 460,000 calls for service in 2002, reduced its "hit" shootings from eight in 1999 to zero for a 16-month period from January, 2002 to May, 2003 showed that more accountability for and more effective supervision by sergeants was a critical –-possibly the most critical – factor. Effective supervision can and does reduce officer-involved shootings. (It should be noted that there were two "non-hit" officer-involved shootings in 2002.) 'Cop Complaints Drop for Fourth Straight Year,' & 'Police Shooting Kills Man in S.J.,' *San Jose Mercury News*, May 2 & 5, 2003; conversation with Lt. Christopher Moore, San Jose Police Department.

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: Supervisors should be held accountable for the performance of the officers under their command whenever a critical incident occurs.

Our review of PPB Training Division materials revealed that the Bureau's existing in-service training program provides sound guidance to supervisors with respect to critical incident management.[183] However, these materials are unclear as to whether the more routine types of "critical incidents," such as the typical "man with gun," call should be considered "critical."

Recommendation 7.6: The foreseeable risks involved require that calls regarding armed civilians, high-risk building searches, and warrant services, should be categorized as critical incidents.

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.

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[183] In-service course for sergeants, detectives and higher ranks, entitled *Critical Incident Management – Basic.* See extract from this document at page 32 of the Appendix.

The following examples of supervisory performance during critical incidents highlight the key problems our review identified:

1. Supervisors coordinating deployment of officers

- At least 16 officers deployed to the vicinity of a "man with a gun" call. No supervisory instruction was given to coordinate their deployment. The officers self-deployed with strategically unsound results.
- A supervisor did not coordinate the actions of multiple units as they initiated a search of a neighborhood for a shooting suspect.

2. Supervisors issuing tactical instructions

- A supervisor overseeing the response to a shooting issued no instructions as to how the suspect was to be apprehended if encountered.
- A supervisor provided no instruction to officers waiting outside a building for an armed suspect, leading to an *ad hoc* response, a crossfire and unnecessary bystander endangerment when the suspect emerged.

3. Supervisors assuming a supervisory role

- Instead of taking a leadership role, a supervisor at the scene of a report of a man with a gun involved himself in the confrontation and handcuffing of a suspect, despite the availability of sufficient officers to perform these tasks.[184]
- A supervisor at the scene of a high-risk, violent arrest failed to issue directions to involved officers attempting to restrain the suspect.

[184] In this case, the supervisor was "instructed" to perform both these tasks by subordinate officers while issuing no instructions himself.

4. Supervisors overruling inappropriate strategies

- A sergeant did not intervene when a lone officer proposed to search the vicinity of an armed, violent suspect's home.
- A sergeant did not offer contrary instruction when an officer proposed a plan that involved unnecessarily precipitating a close-quarters confrontation with an armed suspect.

Although we consider the above-described instances of supervisory performance to fall well below best practice, we were impressed by the exemplary critical incident supervision demonstrated in one of the officer-involved shooting cases we reviewed.[185] In that case, sergeants coordinated the deployment of officers to the scene of a shooting in a well-organized, safety-conscious, and clearly understandable manner. They assumed a leadership role, taking charge of all involved officers' actions. They ensured the effective apprehension of the suspect, provided for officer and bystander safety, and assertively intervened when officers proposed or took tactically unsound action.

It is noteworthy that the above-described commendable performance by the sergeants was not documented in the course of the review of that incident. As a result of that failure, the value of that good practice as a model was likely lost. By the same token, the weaknesses in incident management we have identified were similarly undocumented, and thus were less susceptible to remedy. A review process that systematically fosters emulation of successes and remedy of failures should be considered as an essential basis for the sound management of future critical incidents to which the PPB will be called to respond.

[185] The performance of a sergeant in another officer-involved shooting case also appeared to have been commendable in terms of leadership, communication, and tactical coordination. However, the PPB investigation of that incident garnered scant details concerning the supervisory dimension, making an assessment difficult.

II. FIELD TACTICS

The use of sound, safety-conscious tactics when dealing with an incident where a person is known or suspected to be armed or otherwise dangerous minimizes the chances that officers will find themselves exposed to life-threatening risk. Consequently, the consistent use of sound tactics reduces both the dangers officers face and their need to use their firearms in self-defense.

Our review of officer-involved shooting and in-custody death incidents included a detailed analysis of the tactics used in each case. In each instance where we had a concern with a tactical feature of a case, we referred to the PPB Training Division's curriculum in order to determine the relevant training the Bureau provides to its officers. We also conducted interviews with Training personnel and visited PPB training facilities, taking the opportunity to question trainers on the tactical issues our incident reviews had raised.

Most of the tactical errors we identified were at odds with the tactics taught by the Training Division. Although we did not conduct an exhaustive assessment of the Bureau's training, we did find that its tactical training was generally sound. Moreover, we were uniformly impressed by the high level of professional competence displayed by Training Division personnel. Our interviews with them left us in little doubt that they are capable of training officers to perform policing tasks in a manner that avoids undue danger.[186]

In contrast to our highly favorable impressions of the Training Division, we were struck by the repeated occurrence of tactical errors in PPB field operations: In 22 of the officer-involved shooting cases we reviewed, officers unnecessarily exposed themselves

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[186] We did not observe Training personnel actually engage in officer training. However, our review of lesson plans and interviews with staff left us in little doubt that they perform this function competently.

to the risks presented by dangerous suspects. In most cases, this exposure was a direct result of tactics or techniques that were inconsistent with PPB training.

If the PPB is to minimize the incidence of officer-involved shootings and in-custody deaths, it must ensure that operational performance consistently reflects the high standards set by the Training Division's curriculum and staff. In order to do this, the Bureau must identify lapses when they occur, identify the reasons underlying the lapses, and take effective action to ensure that the lapses do not reoccur.

Based upon our (admittedly limited) assessment of PPB training, there appear to be two major barriers to the full translation of training into practice in the PPB: Firstly, the Training Division's staff appear to operate without the resources they need to realize their full potential. This problem is exemplified by the Division's facilities, particularly with respect to firearms training. We were surprised to discover that a significant portion of PPB firearms training takes place miles outside of Portland in an open-air gravel pit — a facility the training staff considered a major impediment to even their best efforts to provide quality instruction to officers.

The second barrier, which is discussed in detail in Chapter 6 of this report, is a PPB incident-review process that fails to provide the Bureau with the empirical evidence it needs to properly assess the effectiveness of its training program. The Training Division's current operations do not appear to reflect systematic exposure to detailed accounts of deadly force incidents, and we are concerned that the staff who deliver the training cannot properly judge the efficacy of the methods in which they train officers, or of the manner in which training is provided. Until the PPB completes the feedback loop between training and operational experience, it will struggle to properly assess how its Training Division should be managed, both in terms of resource allocation and training content, delivery, and emphasis.

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

Our analysis revealed a number of recurring tactical problems that unnecessarily exposed officers and/or civilians to danger. The following sections discuss the most prominent tactical issues our review identified.

A. High-risk vehicle stops

A significant area of tactical deficiency involved high-risk vehicle stops. Any vehicle stop involving a suspect who is known or suspected to be armed should be considered "high-risk" and demanding of a tactically sound approach by officers. Sound high-risk vehicle stop tactics — such as those taught by the Training Division — involve multiple officers, acting in coordination; provide the protection of distance and cover and/or concealment for those officers; and place suspects at a significant tactical disadvantage from which their ability to launch an effective attack or escape is constrained. In short, sound high-risk vehicle stop tactics provide for the effective apprehension of criminal suspects while minimizing officers' exposure to risk. Failure to use such tactics, conversely, generates unnecessary exposure to risk and a heightened danger that officer-involved shootings will occur.

We identified a number of tactical problems in high-risk vehicle stops that evolved into officer-involved shootings, illustrated by the following examples:

1. Assembling sufficient resources before initiation of stop

- A lone officer attempted to stop two armed robbery suspects without requesting back-up.
- An officer stopped a vehicle used as a getaway from a shooting without requesting back-up.

2. Coordinating actions of officers involved in stop

- Patrol units pursuing a fleeing suspect failed to coordinate their tactics at the end of a vehicle pursuit, creating a situation where police vehicles narrowly avoided colliding with one another as the suspect fired on officers.
- Two units failed to coordinate the stop of an armed suspect and created a crossfire.

3. Considering that hidden person(s) could be in vehicle

- An officer failed to anticipate the possibility of a hidden vehicle occupant when he stopped a vehicle in a shooting investigation, leaving him unprepared when the hidden person ran from the vehicle.

4. Assuming a position of cover/concealment and pointing weapon upon stopping

- An officer ran towards an armed suspect who jumped from a vehicle at the conclusion of a pursuit.
- Officers exited their vehicle at the conclusion of a pursuit without attempting to take cover or draw weapons, leaving them highly vulnerable when a suspect fired at them.

5. Controlling the driver

- In two cases, officers left the driver in a vehicle when they chased a passenger who had run from a high-risk stop.

6. Stopping too close to the suspect's vehicle

- Officers came to a poorly controlled halt just feet away from a suspect's car at the conclusion of a pursuit.
- An officer used the PIT maneuver[187] against an armed suspect in a location where he predictably became trapped in close proximity to the suspect's vehicle.

These multiple problems contrast to Training Division materials which, among other things, instruct officers that they should assume vehicles contain hidden occupants, that four officers should be assembled before the initiation of a high-risk stop, that police vehicles should be stopped 30-40 feet behind the suspect's vehicle, and that high-risk stop tactics should be used at the conclusion of vehicle pursuits.

B. Vehicle pursuits

Our review revealed that in all three cases where a vehicle pursuit of a suspect who was known or suspected to be armed preceded a shooting incident, the manner in which those pursuits were conducted unnecessarily exposed officers to the risk of armed assault. In each case, unnecessary exposure to risk arose from the failure of officers to maintain sufficient distance from the vehicle they were pursuing, placing them within range of any gunshots the pursued suspects might have fired.

Among the tactical problems in vehicle pursuits that evolved into officer-involved shootings were the following:

[187] Precision Intervention Technique, also known as Pursuit Intervention Technique. The PIT is a method used to end vehicle pursuits, by which the pursuing police vehicle initiates contact with the rear quarter panel of the pursued vehicle, causing that vehicle to spin 180 degrees and stall.

1. Describing vehicle[188]

- An officer pursued robbery suspects without broadcasting a description of their vehicle.
- An officer pursued a suspected drug dealer without broadcasting a description of his vehicle.

2. Following armed suspects at a safe distance

- An officer followed a vehicle at a distance of just two car lengths, exposing himself to the risk of being fired upon.
- Officers followed a vehicle at such close quarters that when it stopped, they almost collided with it.

3. Communicating effectively

- An officer involved in a pursuit failed to broadcast a message to indicate to other units that the pursued vehicle had stopped and that a suspect had fled on foot.
- An officer engaged in a pursuit failed to inform assisting units of his belief that a suspect was armed.

4. Supervisors commanding officers to follow tactically sound strategies

[188] In each of the examples provided here, officers did broadcast the license plate numbers of the vehicles in question. This information alone does not necessarily provide assisting units with the information they need to perform their role.

- A supervisor monitoring a pursuit did not issue any contrary instruction to a lone officer pursuing armed suspects, nor did she instruct other units to back-up the officer.
- A supervisor did not repeat a termination instruction when officers failed to respond and continued a pursuit.

Although the PPB's pursuit vehicle policy is generally consistent with national standards, the performance demonstrated in the vehicle pursuits of armed suspects that we reviewed fell well below best practice.

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.

C. Foot pursuits

Foot pursuits are, according to one of the PPB's own training documents, "one of the most dangerous police actions" officers can expect to perform in the course of routine patrol work.[189] The document identifies a long list of "disadvantages" associated with foot pursuits. These include the minimal reaction time an officer has if the suspect stops or produces a weapon, the danger that an officer will be disarmed by a suspect, the difficulty of communicating during a pursuit, the risk of a fatigued officer becoming involved in a physical encounter, officers' exposure to difficult terrain, and the risk that an officer may not know his location at the conclusion of a pursuit.

[189] Supervisor In-Service Training, 1997-1998.

Having listed the tactical disadvantages inherent in foot pursuits, the training document identifies two "Absolute 'DON'TS'":

DO NOT ENGAGE IN A FOOT PURSUIT OF AN ARMED SUSPECT
DO NOT PURSUE AN INDIVIDUAL WITH YOUR GUN OUT

The PPB Training Division is absolutely right to train officers that foot pursuits are dangerous. Furthermore, it is right to train them that under the specified circumstances foot pursuits present such an unacceptable level of danger that they should be avoided.[190]

In five of the six cases we reviewed where officers engaged in foot pursuits, the pursued suspects were known or suspected to be armed. In four of these cases, officers pursued with guns drawn. As such, most of the foot pursuit cases we reviewed violated the Training Division's "absolute don'ts." In none of these cases was a foot pursuit undertaken in the absence of available alternative strategies, or in circumstances that would otherwise render the use of the tactic appropriate.[191]

Unless properly limited, the use of foot pursuits will unduly expose officers to danger. That exposure will, in turn, increase the likelihood that officers will become involved in shootings. Careful management of foot pursuits is a must if the risk of avoidable officer-involved shootings is to be minimized.

[190] We recognize that, in extreme circumstances, it may be necessary for officers to engage in a foot pursuit of an armed suspect, and such circumstances may require an officer to draw his or her weapon during a pursuit. However, pursuits of armed suspects should only be undertaken as a last resort in cases where no alternative strategy is feasible and a delay in the apprehension of the suspect would present a threat of death or serious injury to others.

[191] It should be noted that two of the cases occurred before foot pursuit training was introduced, and thus before the PPB had established its "absolute don'ts." However, in both of those cases the involved officers' tactics were clearly dangerous. (These problematic tactics were not documented in the review process in either case.)

Limiting officers' use of foot pursuit tactics does not mean that suspects should be allowed to escape whenever they decide to run from the police. Alternative tactics that provide for both the effective capture of suspects and the maximization of officer and suspect safety are widely practiced by U.S. law enforcement agencies. The most commonly-practiced alternative to foot pursuits is "containment," where the area into which a suspect flees is surrounded and systematically searched by a coordinated team of officers.[192] Indeed, our review identified instances where PPB officers used such tactics to great effect.[193]

Although the PPB's foot pursuit training program represents a step in the right direction, more is needed. Research — underscored by the foregoing discussion — has shown that training alone does not guarantee that officers will not engage in dangerous foot pursuits.[194]

Recommendation 7.11: In order to effectively prevent the unnecessary exposure of its officers to the risks associated with foot pursuits, the PPB needs to adopt and vigorously enforce a foot pursuit policy mandating the use of sound tactics by officers who encounter fleeing suspects.

The International Association of Chiefs of Police (IACP) recently published a "Model Policy" for foot pursuits — a move indicative of such policies' status as a best

[192] It should be noted that the use of air support can aid significantly in the apprehension of fleeing or hidden suspects.

[193] In a case where an officer was fatally shot by a suspect during a foot pursuit (an incident that occurred before foot pursuit training was introduced), a second pursuing officer wisely decided to abandon the pursuit once shots had been fired. A containment was established around the area into which the suspect had fled and apprehension by a canine unit followed shortly thereafter.

[194] See Special Counsel Merrick J. Bobb and Staff and PARC, "Dangerous foot pursuits," *Los Angeles County Sheriff's Department, 16th Semiannual Report,* February 2003. In the course of researching that report, PARC reviewed 52 foot pursuit cases where an officer-involved shooting occurred and a further 250 where no shooting occurred. The report concluded that, despite pertinent training, dangerous foot pursuits still occurred with alarming frequency.

practice.[195] Additional foot pursuit policy models can be found in operation in the Collingswood, New Jersey Police Department and the Cincinnati Police Department (included in the Appendix at pages 48 and 44). Furthermore, a number of agencies, including the Miami Police Department and the Los Angeles County Sheriff's Department are currently in the process of developing similar policies.

D. Use of Cover

"Cover" is any material or object behind which an officer can position him or herself for protection from gunfire or other threats. The use of cover is a basic tactic police officers can deploy to protect themselves from the threats posed by armed or potentially armed suspects. Officers who engage suspects from behind cover will not face the same level of danger as those who do so from an exposed position. The consistent use of cover by police officers facing known or suspected threats reduces officers' exposure to danger and, consequently, reduces the risk that they will become involved in a shooting. As is the case with basic tactical training provided by virtually all law enforcement agencies, the PPB trains its officers in the use of cover. The Bureau must ensure that officers comply with this basic aspect of their training.

Our review of officer-involved shootings revealed 21 incidents where officers' failure to use cover effectively had unnecessarily exposed them to risk. Such actions represent basic tactical errors, and are exemplified as follows:

- Officers did not use readily available cover when they approached a vehicle containing a suspect who had shot an officer minutes earlier.

[195] IACP National Law Enforcement Policy Center, *Foot Pursuits: Concepts and Issues Paper*, February 2003.

- Officers hidden behind the corner of a building deliberately jumped into the path of an approaching armed suspect, directly exposing themselves to the threat he presented.

In just two of the 21 cases in which we found a problem relating to officers' use of cover was that problem noted in the PPB file. Given that cover is such an elementary tactical issue, this omission points to striking inadequacies in the review process.

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

E. Crossfires

The danger officers face when they become involved in armed confrontations does not always arise solely from the actions of criminal suspects. Whenever an officer draws his or her firearm, that firearm becomes a potential source of danger to other officers present. In order to manage this risk, it is imperative that officers consistently avoid creating crossfires — situations in which officers position themselves in line with actual or potential "friendly fire."

Although none of the incidents we reviewed saw officers harmed by police gunfire, there were four cases in which officers appear to have created crossfires.[196] These potentially lethal scenarios, typified by the following examples, were principally a consequence of poor officer coordination — an issue featured in our earlier discussion of critical incident management:

- As a group of officers held a suspect at gunpoint, a patrol unit drove into the street and stopped directly in the officers' lines of fire.

[196] We found no instances in which the PPB's own review had noted a crossfire as a problematic incident feature. In several cases, individual officers told investigators that crossfires had occurred. However, these reports did not prompt comments from PPB reviewers.

- An officer armed with a rifle took a position opposite numerous patrol vehicles. The officer did not know whether or not officers were in or behind those vehicles. A barricaded suspect was positioned between the officer with the rifle and the vehicles. The officer with the rifle repeatedly asked for confirmation of whether other officers were in his line of fire, unsure whether it was safe for him to fire his weapon.

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

F. Bystander endangerment

Although officers' exposure to risk during encounters with dangerous or potentially dangerous suspects should always be a key tactical consideration, the necessity of minimizing bystanders' exposure to danger is equally important. Nonetheless, in four cases, bystanders appear to have been unduly endangered.[197] The PPB should ensure that such endangerment is minimized in future operations. Incidents of bystander endangerment we identified included the following:

- Officers did not evacuate streets surrounding the location of an armed suspect, despite having ample time and resources to do so. The suspect was subsequently confronted next to the window of a building containing numerous civilians.

- Officers fired multiple shots through the darkened rear windshield of a stationary SUV in an attempt to hit the vehicle's driver. They did so without establishing whether the vehicle contained any passengers. (Had there been passengers in the rear seat, they could have been killed.)

[197] As with crossfires, bystander endangerment was typically the product of poorly coordinated responses to dangerous incidents and was never documented as a matter of concern by PPB reviewers.

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

III. SHOOTING AT MOVING VEHICLES

Of the 30 cases we reviewed in which PPB officers fired their weapons, four involved shots fired at moving vehicles. In three of the cases, the officer was not returning gunfire from the suspect, but rather asserted he was firing to prevent the driver from running him over. Many major law enforcement agencies have become sufficiently concerned with the risks associated with shooting at moving vehicles that they have adopted strict policies that either ban such shots or narrowly restrict the circumstances under which officers may fire.

In contrast, the PPB's policy is vague. The PPB's deadly force policy, embodied in Manual Section 1010.10, at 404 (2002), states that:

> A member justified in using deadly physical force may shoot at, or from, a moving vehicle if, in the totality of the situation, the additional risks are clearly outweighed by the need to use deadly physical force.

This policy provides inadequate guidance to officers and is unlikely to minimize the incidence of dangerous and ineffective shootings that can result from poorly managed encounters between officers and vehicles.

Gunfire is generally ineffective as a means of bringing vehicles to a halt. Whether shots are fired with the intention of disabling a vehicle itself, or of incapacitating the driver, the most likely outcome of such a shooting is that a vehicle will continue moving for some distance before stopping. And once shots have been fired, a vehicle is unlikely to be under control and may injure or kill people before coming to a

halt.[198] In circumstances where a vehicle is being driven at officers in order to cause them harm, the ideal response by the officers is to move out of the vehicle's path if at all possible.

Police gunfire failed to stop the vehicles at which it was directed in all the relevant PPB cases we reviewed. In one of those cases, an officer returned fire after being shot by the driver of a vehicle. In the remaining three, the involved officers reported that they fired because they feared they would be struck by the vehicles in question. In none of these three cases was the officer actually struck. In one instance the officer not only failed to stop the vehicle, but instead shot a person sitting in the front passenger seat. These three cases serve to underline the point that gunfire is a generally ineffective and dangerous means of stopping moving vehicles. Moreover, the fact that the three officers who fired to prevent themselves from being struck all ultimately avoided injury by moving out of the paths of the approaching vehicles highlights the value of simple evasion as an officer-survival tactic.

Policies on Shooting at Moving Vehicles

Los Angeles Sheriff's Department
The use of firearms against fleeing or approaching vehicles has proven to be generally ineffective and inherently dangerous. Department members shall not fire at a moving vehicle, whether to disable the vehicle or to stop the suspect, unless they have probable cause to believe that the suspect represents an immediate threat of death or serious physical injury to the Deputies or other person(s). Members shall take into account the location, vehicular and pedestrian traffic and any hazard to innocent persons before firing at a moving vehicle. Department members shall not place themselves or remain in the path of a moving vehicle.
Los Angeles County Sheriff's Department Manual of Policy and Procedures 3-01/025.30

Los Angeles Police Department
Firing at or from moving vehicles is generally prohibited. Experience shows such action is rarely effective and is extremely hazardous to innocent persons.
Los Angeles Police Department Manual 556.40

Cincinnati Police Department
Officers shall not discharge their firearms at a moving vehicle or its occupants unless the occupants are using deadly force against the officer or another person present, by means other than the vehicle.
Cincinnati Police Department Manual 12.550

State of New Jersey
While any discharge of a firearm entails some risk, discharging a firearm at or from a moving vehicle entails an even greater risk of death or serious injury to innocent persons. The safety of innocent people is jeopardized when a fleeing suspect is disabled and loses control of his or her vehicle. There is also a substantial risk of harm to occupants of the suspect vehicle who may not be involved, or involved to a lesser extent, in the actions which necessitated the use of deadly force.
a. Due to this greater risk, and considering that firearms are not generally effective in bringing moving vehicles to a rapid halt, officers shall not fire from a moving vehicle, or at the driver or occupant of a moving vehicle unless the officer reasonably believes:
(1) there exists an imminent danger of death or serious bodily harm to the officer or another person; and
(2) no other means are available at that time to avert or eliminate the danger.
b. A law enforcement officer shall not fire a weapon solely to disable moving vehicles.

New Jersey Attorney General's Use of Force Policy I.C.6.

[198] The ineffectiveness and danger associated with shooting at moving vehicles is taken sufficiently seriously by some agencies that they specifically identify these problems in policy statements.

The best practice among law enforcement agencies is that the use of police firearms against moving vehicles should be narrowly restricted. Several police departments, such as those in New York City and Cincinnati, go as far as strictly prohibiting shooting at a vehicle unless countering a non-vehicular threat (e.g., gunfire) from one of the occupants.

In our view, however, such flat-out bans go too far in certain instances, such as where an officer or civilian is placed in a confined area and is unable to move out of the way of a speeding car. In such instances, the use of firearm may be appropriate. Jurisdictions allowing the use of a firearm, when no other alternative exists, include the State of New Jersey,[199] which restricts shooting at or from a moving vehicle to circumstances where there is imminent danger of death or serious injury *and* there is no alternative. (See page 48 of the Appendix for the text of the policy.)

Recommendation 7.15: The PPB should revise its deadly force policy in two respects. First, the policy should contain a brief preface explaining that shooting at moving vehicles is dangerous and generally ineffective. Second, the policy should give PPB officers specific guidelines, such as the following:

- 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 fire at a moving vehicle only 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.

[199] The New Jersey policy, formulated by the state Attorney General, must be followed by all law enforcement agencies in New Jersey, including the State Police.

- 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.

We make these recommendations confident that PPB officers, like officers in other jurisdictions, will be better served by focusing their efforts on not putting themselves in the path of — or getting out the way of — speeding vehicles, rather than trying to protect themselves by taking the time to draw, sight, and fire their sidearms. The adoption of such a policy is an essential element of an effective risk management program, as well as a best practice.

IV. EQUIPMENT ISSUES

The availability of equipment required for safety conscious, effective policing, and the proper handling of police equipment, are important elements of any law enforcement agency's risk management program. Our incident review process identified a number of equipment-related issues with risk management implications.

A. Handling of firearms

Firearms must be handled appropriately at all times if the risks inherent in their use are to be minimized. In the context of police work, the key risks associated with firearms handling arise from accidental discharges[200] and misdirected shots. All police officers should possess sufficient competency in firearm handling to avoid these risks, and should rigorously and consistently practice safe firearm handling.

[200] Accidental discharges are also referred to as "negligent discharges."

Our review identified six cases in which PPB officers apparently did not handle their handguns appropriately. The degree to which we can draw firm conclusions about these incidents is limited due to the fact that the PPB investigative process did not examine firearms handling issues in any detail in the cases in question.[201]

1. Accidental Discharges

An accidental discharge occurs when a gun is unintentionally fired due to its being mishandled — always a dangerous occurrence. Safe and competent firearms handling is a basic professional requirement in police work and officers should assiduously avoid any handling technique that presents a risk of an accidental discharge. Such discharges typically result from officers' failures to keep their trigger finger outside of the trigger guard of their weapon until they intend to fire — a basic handling error that PPB officers are all trained to avoid.

Circumstantial evidence in four officer-involved shooting incidents suggests that the officers accidentally discharged their weapons. In each case the weapon discharged was a Glock semi-automatic pistol — the Bureau-issued sidearm. In none of the cases did an officer state that the discharge was accidental, nor was there any documented probing of that possibility by investigators.[202]

The potential accidental discharge cases we identified were characterized by the following circumstances:

- Single round discharged;

[201] In the future, the PPB should treat firearm handling issues as a key incident feature deserving of thorough investigation in officer-involved shooting reviews.

[202] It should be noted that the scope of our review did not include cases the PPB classified as accidental discharges.

- Multiple officers confronted the same threat with weapons drawn and pointed, but only one officer fired;[203]
- Discharged round did not hit suspect.

Although we readily concede that these incident characteristics, either alone or in combination, do not in themselves mean that an accidental discharge occurred, specific details of each case bolstered our concerns. In one case, for example, an officer told investigators that his shot "went off" — an unusual choice of words if the officer was describing an intentional discharge. In another, a witness officer told investigators that he thought his colleague had fired accidentally,[204] and a supervisor (who was standing next to the involved officer at the moment in question) told investigators that the suspect had already dropped his weapon when the shot was discharged.

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.[205]

2. Single- and weak-hand shooting

A considerable degree of skill and coordination is required to fire a handgun accurately. In firearms parlance, a person's more coordinated hand (*i.e.,* the hand with which one writes) is the "strong" hand, while the other hand is the "weak" hand.

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[203] This circumstance applies to three of the four potential accidental discharge cases we identified. In the fourth case, the officer who may have accidentally discharged his weapon was working alone.

[204] This observation was reported in a pre-interview summary. Unfortunately, the issue of a possible accidental discharge was not raised in the witness officer's tape-recorded interview, and the details and basis of his belief were never documented.

[205] The Cincinnati Police Department — an agency currently undergoing reform in accordance with the terms of a Memorandum of Agreement with the Department of Justice — has addressed this issue with the implementation of a policy dictating that an officer's finger "is only to be placed on the trigger when on target and ready to engage a threat." (Cincinnati Police Department Procedure Manual, 12.550) Although we do not believe that the PPB necessarily needs to implement a policy in order to achieve trigger-finger discipline by its officers, the Bureau must act to ensure that such discipline is consistently maintained.

Accuracy is best achieved when both hands are used to hold the weapon, with the strong hand operating the trigger. Single- and/or weak-handed firing are almost certain to produce sub-optimal results.[206]

Whenever police officers find themselves confronted with the need to fire their weapons, it is essential that they do so as accurately as possible: misdirected shots extend the time that will elapse before the threat a subject poses is neutralized, increase the risk that an officer will deplete his or her ammunition before stopping a threat, and increase the chances that a round will unintentionally harm someone or something. Thus, officers should, whenever feasible, hold their weapons in a strong, two-handed grip. We understand that certain circumstances, such as incapacitation as the result of injury, a pressing need to hold a person or object, or a need to shoot from certain positions of cover, may preclude the use of this ideal option, and that training must provide the skills required in such scenarios. Nevertheless, a strong, two-handed grip should always be considered preferable.

Our review of PPB officer-involved shooting incidents revealed that, in four cases, officers fired using single- and/or weak-hand grips on their weapons.[207] In every case, these shots failed to find their target.[208] In three of these cases, it appeared to us that a strong, two-handed grip could have been used in place of the inferior alternative.

In two cases we noted that officers switched their weapons from their strong to weak hands in order to lead with their weapon side as they rounded a corner. The

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[206] PPB officers use both 9mm and .45 caliber pistols. The handling issues discussed here apply to both calibers of weapon, but are especially pronounced with the .45 due to the greater power of those weapons.

[207] It appears that in several cases involving single-handed shooting officers were using their support hand to hold a flashlight. Small, powerful flashlights that can be used without abandoning a two-handed grip, or that can be mounted on a firearm, are available and are used by some law enforcement agencies. Although we do not have sufficient information to determine whether the use of such flashlights represents an ideal solution, the PPB should investigate developments in illumination tactics and technology to ensure that its officers are equipped with the best available tools for dealing with low-light incidents.

[208] In one single-handed shooting, the officer's round hit the suspect in the arm. However, the intended target of the shot was "center mass" and the suspect was only partially incapacitated by his injury.

Training Division confirmed that they train officers in the use of this technique, with the caveat that it should only be performed if officers feel confident in their weak-hand shooting ability. Although there may be some benefit in leading with weapon-side when maneuvering around corners, in the two cases where this technique led to a weak-hand shooting, any potential benefit seemed to be more than outweighed by the officers' subsequent failure to fire accurately.

Recommendation 7.17: The PPB should reconsider how it trains officers in this weak-handed shooting technique in light of experience that shows the poor level of accuracy associated with its use. [209]

B. Less-Lethal Weapons

In certain circumstances, less-lethal weapons — weapons that can incapacitate with a low associated risk of inflicting life-threatening injuries — can be used to subdue violent suspects without unduly endangering police officers. When the only alternative is the use of a firearm, the deployment of less-lethal weapons can obviate the need for an officer-involved shooting and potentially save a suspect's life. Conversely, failure to appropriately deploy less-lethal weaponry heightens the risk of avoidable deaths or serious injuries. The Bureau's interest in, and deployment of, less-lethal alternatives to firearms demonstrates a commendable commitment to using the least force necessary to protect officers and the community.

The field of less-lethal weapon technology and usage is rapidly evolving, and significant changes have occurred since the end of the period covered by our review. Nevertheless, the lessons that can be drawn from our review sample with respect to the

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[209] The recommendation that the PPB reconsider how this technique is trained should not be taken as a suggestion that the technique itself be abandoned, as the principles upon which is it based are sound. However, in the two relevant cases we examined it appears that officers over-estimated their weak hand shooting abilities. A reconsideration of training should focus on the question of how best to provide officers with the requisite measures of skill and judgment to enable them to use the technique appropriately and effectively.

availability of less-lethal options to officers, and the propensity of officers to consider the use of such weapons in lieu of more dangerous alternatives, remain pertinent.

1. Beanbag shotguns[210]

Although all PPB patrol officers are equipped with widely-used less-lethal weapons, batons and canisters of pepper spray, a more formidable less-lethal option available for patrol use during our review period (and the option whose use arose as an issue in our review) is the beanbag shotgun. This weapon is a regular shotgun loaded with a less-lethal round — essentially a fabric bag containing lead shot — designed to incapacitate a person without causing a life-threatening injury.[211] In three of the cases we reviewed, the PPB employed this less-lethal alternative.

Before turning to the circumstances of those cases, we address a significant training issue. PPB officers are trained that beanbag shotguns should be deployed only alongside "lethal cover." According to the Training Division, the requirement for "lethal cover" does not necessarily mean that the cover officer should draw a firearm. Rather, officers supporting an officer deploying less-lethal force should equip themselves with whatever force option is most appropriate in the circumstances. Some circumstances may require a cover officer to draw and point a firearm, while others may render a baton or chemical spray more suitable.

The plain meaning of the "lethal cover" requirement, however, is that firearms should always be drawn. Indeed, just such an understanding was reflected in an account provided to investigators by an officer who had been involved in an officer-involved shooting incident involving the deployment of a beanbag shotgun.

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[210] Our review covered discharges of beanbag (also known as stunbag) shotguns only to the extent that they occurred in cases where there was also a discharge of a (lethal) firearm.

[211] In order to minimize the potential for the infliction of serious injury or death, beanbag rounds should not be fired at vital areas of a subject's body, and should be used only from distances recommended by the manufacturer.

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.[212]

A beanbag shotgun was discharged in three officer-involved shooting cases we reviewed.[213] Two of these cases demonstrated the benefits of the beanbag shotgun, while one demonstrated its limitations:

- Officers encountered a person armed with a knife. Appropriately recognizing that the situation could potentially be resolved without resort to deadly force, they requested that a beanbag shotgun be brought to the scene. The weapon was readily available and was deployed. The weapon proved effective and facilitated the safe apprehension of the suspect who, were it not for the availability and use of less-lethal weaponry, might well have been shot.

- Despite having been hit in an exchange of gunfire with officers, a suspect refused to comply with commands given to him. A beanbag shotgun was used to gain compliance, facilitating the suspect's safe arrest.

- Officers determined that a beanbag shotgun might enable the safe apprehension of an aggressive suspect. The subject was not incapacitated by the four rounds fired at him and an officer ended up shooting him.

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[212] Although the PPB had not introduced the M-26 Taser during the period covered by our review, we were provided with a PPB *Tips and Techniques* circular dated June 19, 2002, which counseled officers as follows: "Tactics used with the M-26 taser are consistent with those currently used with [the] less lethal shotgun, and require the use of *lethal cover* upon taser deployment" (emphasis added). Our comments apply equally to the use of cover for taser deployments.

[213] We also identified a case where a beanbag shotgun *might* have proved a viable alternative to the handgun that was used to subdue a man armed with a knife. We say "might" because the PPB investigation did not contain sufficient information for an objective determination on this point. Future investigations of officer-involved shooting incidents should comprehensively address the issue of whether a less-lethal option could feasibly have been deployed.

To the limited extent that we can generalize from only three instances in a three-and-one-half-year period, it appears that the PPB made the beanbag shotgun available when required. Our small sample shows that the beanbag shotgun sometimes works and sometimes does not. We note that, more recently, the PPB has introduced both the M-26 Taser and the Sage SL1 projectile launcher for patrol 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.

C. Radio Noise

The problem of noise from personal radios betraying officers' presence to suspects arose in two cases we reviewed.

Recommendation 7.20: This noise problem could easily be avoided if the PPB provided its officers with radio earpieces, a relatively inexpensive step we recommend the PPB take without delay.

The need for stealth is not uncommon in police work. Without earpieces, officers must risk their radios being heard or render themselves uncontactable by turning down the volume. Neither of these options is compatible with risk-conscious police operations.

D. Helicopter

Although many of the risks our review identified could have been avoided using available resources, the introduction of a helicopter air support unit — which does not presently exist — would materially reduce the risks to the safety of both officers and civilians.

According to the U.S. Department of Justice, 62 percent of local police departments serving populations of between 500,000 and 999,999, and 52 percent of those serving between 250,000 and 499,999, operated a helicopter in 2000.[214] The PPB, which serves a population of just over 529,000,[215] currently has no helicopter. Our review of officer-involved shootings revealed that in 14 cases, the involvement of a police helicopter could have positively contributed to the safety of involved officers and/or civilians. In every case, this potential reduction in risk would have stemmed from officers' increased capacity to assess situations and to maintain a greater distance from the suspect until a tactically sound apprehension strategy could be implemented.

The operational advantages that stem from the availability of helicopter support to police ground units are many. A 2001 study conducted by the Canadian Police Research Centre found that advantages associated with the use of a police helicopter in a Canadian jurisdiction included:[216]

- Prompt police response to incidents.
- Increased efficiency of ground units.
- Higher apprehension rates.
- Enhanced search capabilities (both in terms of search effectiveness and safety).
- Improved officer safety.[217]

By virtue of the superior observations offered by an airborne position, coupled with the aircraft's standard illumination, night-vision and video equipment, a police helicopter unit can play a significant role in reducing officers' exposure to danger and the

[214] U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Local Police Departments 2000*, January 2003.

[215] Portland Police Bureau 2000 Statistical Report, *Community Policing: Focus on the Future*, January 2001.

[216] The Canadian Police Research Centre, *The Eye in the Sky: Evaluation of Police Helicopter Patrols,* available on-line at http://www.cprc.org/tr/2001/01/tr-2001-01-R2.pdf.

[217] For more information on the use of police helicopters, see Alpert, G.R., "Helicopters in Pursuit Operations," National Institute of Justice (1998).

associated risk that they will become involved in a shooting. The following operational advantages that helicopter support can provide would all have reduced risks to PPB officers and civilians had a helicopter been available in the officer-involved shooting incidents we reviewed:

- Enhanced assessment of unfolding incidents.
- More effective tactical coordination of ground units.
- Enhanced capacity to locate and monitor dangerous suspects (regardless of lighting conditions), reducing the need for officers to engage in deployments that could place them in tactically disadvantageous positions.
- Safer tracking of dangerous suspects, reducing the need for high-risk tactics such as vehicle- and foot-pursuits.
- Capacity to illuminate poorly-lit incident scenes.

It is often the case that the proposals to introduce a police helicopter unit prompt opposition from community members concerned about issues such as noise and light pollution and high operating costs. While it is only right that a decision as important as the purchase of a helicopter should be subject to debate and careful consideration, it should be borne in mind that the greater likelihood that dangerous incidents will be resolved without death or injury to officers or civilians should weigh heavily in this calculus.

Recommendation 7.21: We recommend that the Bureau establish a helicopter unit as an important element of a risk management program.[218]

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[218] The PPB currently has a fixed-wing aircraft. However, this resource was not deployed in any of the incidents we reviewed. Although a helicopter is superior to a fixed-wing aircraft, fixed-wing air support is better than no air support at all. If it is determined that the PPB cannot be provided with a helicopter, we recommend that the availability of existing air support resources be maximized.

V. POLICE ENCOUNTERS WITH INDIVIDUALS WITH MENTAL ILLNESS OR SUICIDAL IDEATION

Our review included six instances in which members of the PPB encountered individuals with mental illness or persons actively pursuing suicide. In some of those cases the subjects' mental illness or suicidal ideation was known to the officers beforehand, sometimes it was not. In every case, however, that illness added a heightened level of unpredictability and associated risk to the encounter. What each actor brings to an encounter between a police officer and a person suffering mental illness will differ. On the side of the police officer, there will be wide variations in age, experience, maturity, culture, training, attitudes toward those with mental illness, and opportunities to exercise skills developed in training. On the side of the individual confronted, there too will be the same wide variations in background, including attitudes or assumptions about the police, and varying capacities to understand and assimilate instructions and to bring themselves into self-control. These are not easy cases from any perspective.

Many law enforcement agencies — including Portland — have the capacity to provide a specialist response to incidents involving individuals with mental illness. In the PPB, this specialist response is provided by Crisis Intervention Team (CIT) officers. CIT officers receive specialized training in dealing with individuals with mental illness or suicidal ideation, and learn to slow down and de-escalate incidents, negotiate with subjects, and respond more flexibly. According to the PPB's CIT Coordinator, 193 PPB officers have received CIT training since it was introduced in 1995, and approximately 25 percent of patrol officers are currently CIT-trained.

Portland's CIT model was patterned after the one used by the Memphis Police Department, which is often-cited as an example of best practice in the area.[219] In November 2000, *The Journal of the American Academy of Psychiatry and the Law*

[219] Memphis is a city of approximately 630,000 residents, and its police department employees some 900 uniform patrol officers. Of that, the Department of Justice reported that 213 have received critical incident training. *Bureau of Justice Assistance Bulletin from the Field Practitioner Perspectives,* July 2000.

published a study of Memphis's CIT model.[220] As in Portland, the Memphis CIT training takes 40 hours and "focused on scenarios developed from actual incidents. These scenarios allowed for the illustration of crisis de-escalation principles and included intensive feedback from fellow officers and mental health professionals."[221] Four distinct benefits flowed from implementation of a CIT model in Memphis where, because over 25 percent of all uniformed patrol officers had been trained, there were CIT-trained officers available on every shift in every precinct:[222]

1. *Timely response.* In 100 randomly selected cases, a Memphis CIT officer arrived in fewer than ten minutes, "with the great majority of those calls responded to in under five minutes."
2. *Decreased need for SERT or SWAT teams.* De-escalation training in Memphis decreased the need for such teams. The more instances in which CIT was used, the fewer instances when Memphis's SWAT team was called out.
3. *Decreased Officer Injuries.* In Memphis, officer injuries in encounters with persons with mental illness dropped by more than half following implementation of CIT and, based on anecdotal evidence, so did injuries to the involved individuals with mental illness.
4. *Reduced Criminalization of Mental Illness Events.* The arrest rate of persons with mental illness dropped after introduction of CIT to approximately two percent as contrasted to a national average of 20 percent. "The Memphis CIT officers have increased their department's involvement in mental illness events and referrals to the health care system. This increase has happened while they have maintained an extremely low rate of

[220] Dupont, R. and Cochran, S., "Police Response to Mental Health Emergencies — Barriers to Change," *J Am Acad Psychiatry Law* 28:338-44, 2000.

[221] *Id*. at 339.

[222] *Id.* at 340.

arrest for those with mental illness, while at the same time significantly reducing their own injury rate."[223]

It is not possible to determine from the small sample of relevant cases we reviewed whether Portland's version of the Memphis CIT program has achieved similar results.[224] Nor can we say whether the subjects in the relevant cases we reviewed would have been responsive to even letter-perfect application of CIT techniques. However, our review did identify some CIT-related areas of concern to which the PPB should pay close attention:

A. Use of de-escalation techniques

We were concerned by what appeared to have been missed opportunities to attempt de-escalation in two cases involving subjects with mental illness. Although this is a small number, these cases represent one third of the officer-involved shootings and in-custody death incidents we reviewed involving persons with mental illness and suicidal ideation. Moreover, de-escalation is an elementary technique for dealing with aggressive subjects suffering from mental illness, and any failures to attempt the technique should be considered as significant omissions.

B. Failure to deploy CIT officers

We were also concerned that CIT officers did not appear to have been deployed in one of the two incidents where the PPB had a prior indication that such a deployment

[223] It should also be noted that a police response team is not the only model currently being employed in the United States. Another model involves the police department's hiring of mental health professionals who are not sworn officers to provide "on-site and telephone consultations to officers in the field." Borum, R., Improving High Risk Encounters Between People with Mental Illness and the Police," *J Am Acad Psychiatry Law* 28:332-37*, at 334,* 2000. A third model involves "partnerships or cooperative agreements . . . between police and mobile mental health crisis teams that exist as part of the local community mental health services system and operate independently of the police department." *Ibid*.

[224] Aside from the difficulties of drawing firm conclusions on the basis of a small sample of cases, our ability to comment on CIT issues is constrained by the scant documentation of CIT considerations in the files we reviewed.

would be appropriate. Moreover, we noted that in one case a CIT officer apparently did not attempt any specialist CIT techniques, despite being present at the scene of an incident involving an individual with mental illness.

The deployment omission we identified may indicate that the CIT arrangements in place during our review period were insufficient to ensure the consistent application of CIT skills to incidents involving subjects with mental illness. In order to realize the benefits of its CIT program, the PPB must work to ensure that its deployment of CIT officers is sufficient to create a CIT response whenever the need arises, that CIT-type incidents are assigned to CIT officers whenever feasible, and that CIT officers are diligent in following their training when they attend such incidents.

Although we lack sufficient information to make overall judgments in respect to these issues in relation to the period covered by our review, we were concerned by a relatively current indication that the PPB does not provide as comprehensive a CIT service as it might: According to the May/June 2003 edition of the PPB's CIT newsletter, CIT officers were available to deal with just one third of the CIT-related calls the Bureau received during the first three months of 2003. This figure suggests that there is room for improvement in the Bureau's deployment practices. The PPB's goal should be to deploy a CIT officer to every call where such an officer's presence could be beneficial.

Recommendation 7.22: The PPB should ensure that CIT officers consistently exercise their specialist skills when dealing with CIT-related incidents.

Recommendation 7.23: We encourage the Bureau to examine its current practices in order to identify means of improving deployment rates of, and better capitalizing on the skills possessed by, its pool of CIT officers.

C. Sudden Death Syndrome[225]

Since at least 1988, the PPB has trained its officers not to leave a restrained prisoner in a face-down position because it increases the risk of in-custody death, and that this risk is particularly pronounced when the prisoner is under the influence of drugs or alcohol, or is obese.[226] In 1998, the Bureau produced a detailed training bulletin on "Sudden Death Syndrome"[227] that alerted officers to a series of factors that can indicate that an individual is at risk for in-custody death and providing guidelines for minimizing that risk.[228] Featured in the 1998 bulletin were instructions that a prisoner exhibiting sudden death syndrome risk factors — which include violent behavior, removal of clothing, and extraordinary strength — should not be placed in a position that could significantly restrict breathing, and that such a prisoner's apparent medical condition should be closely monitored. The guidance provided by the 1998 training bulletin is comprehensive and consistent with best practice. Bureau policy since at least 1995 has also required that prisoners should not be allowed to remain in a face-down position; should, upon restraint, be immediately moved into a position that facilitates uninhibited breathing; and should be subject to special attention if certain high-risk behaviors have been exhibited.[229]

We were concerned that in both in-custody death cases we reviewed, the involved officers' actions did not reflect the high standard of care and best practices embodied in PPB training and policy documents. Specifically, involved officers appeared not to take

[225] While the issue of sudden death syndrome does not apply only to those with mental illness, we raise it in this section of the report as it emerged as an issue in our review sample in relation to such individuals.

[226] PPB Training Bulletin, vol. XXIV, No. 6, "Handcuff Precautions," March 10, 1988.

[227] PPB Training Bulletin, vol. XXXIV, No. 1, "What Is the 'Sudden Death Syndrome' (SDS)," January 12, 1998.

[228] Both of the in-custody deaths we reviewed occurred after this training bulletin was produced.

[229] General Order 870.20, at 5 (April 10, 1995). The substance of the current version of this policy is identical. PPB Manual § 870.20 at 375, ¶ (a)(1-3) (2002).

into account obvious sudden death syndrome risk factors when deciding upon how to restrain the two individuals in question.

Recommendation 7.24: The PPB should ensure that officers consistently perform according to both policy and training in order to minimize the future occurrence of in-custody deaths.

VI. RECOMMENDATIONS

As the above discussions illustrate, our review of PPB officer-involved shooting and in-custody death incidents revealed that the Bureau could improve its management of risk in relation to several areas of operational police work. Our recommendations, designed to improve the safety of both officers and civilians, are summarized below:

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.

Recommendation 7.2: The PPB should ensure that the incidence of communications failures during police operations is minimized.

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.

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.

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

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

Recommendation 7.7: The PPB should emphasize the relevance of supervisors' critical incident training to routine police operations.

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, crossfires and bystander endangerment.

Recommendation 7.9: The PPB should ensure that supervisors consistently manage vehicle pursuits to a high standard.

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

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

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

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

Recommendation 7.14: The PPB should ensure that the incidence of endangerments to bystanders is minimized.

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.

Recommendation 7.16: The PPB should take steps to minimize the risk of accidental discharges.

Recommendation 7.17: The PPB's Training Division should reconsider its current training in maneuvers that involve weak-handed shooting.

Recommendation 7.18: The PPB should abandon use of term "lethal cover" in relation to less-lethal weaponry training and deployment.

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.

Recommendation 7.20: The PPB should provide all operational personnel with a radio earpiece.

Recommendation 7.21: The PPB should establish a helicopter unit.

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.

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.

8. Management of Records and Information

One of the most significant innovations in policing in the past ten years has been the proactive use of data to fight crime and manage police resources. COMPSTAT, a data analysis approach that uses computer mapping software to pinpoint crime locations, has spread from the New York City Police Department, where it originated, to police departments around the globe. The Pittsburgh Police Bureau and the Los Angeles County Sheriff's Department have received national praise for their quarterly COMPSTAT-like analyses of risk-related issues, including officer-involved shootings and in-custody deaths. The policing world has come to recognize that information management generates power that can be harnessed to accomplish both law enforcement and organizational goals.

PARC did not set out to evaluate the PPB's management of records and information, and we did not expand our project to seek any information on these subjects beyond what was necessary to accomplish an effective review of the 34 officer-involved shooting and in-custody death incidents and of the Bureau's policies and procedures relating to such cases. Nevertheless, in conducting our officer-involved shooting and in-custody death review, we made a number of observations that require brief mention in this report.

I. Proactive Information Management

In 1992, following the high-profile death of Nathan Thomas,[230] the PPB released a valuable statistical study on 29 officer-involved shootings that occurred between 1988 and early 1992. Much of the information in the PPB's study, which was prepared by the Training Division, was similar to the data in Chapter 2 of this report. PARC received a copy of the 1992 PPB report from a source outside the PPB. When PARC asked the PPB

[230] Nathan Thomas was a 12-year-old boy who was taken hostage in his bedroom by a knife-wielding burglar. In an attempt to save him, officers shot at the burglar, killing both him and Nathan Thomas. The incident is considered both inside and outside the PPB as one of its most traumatic events.

for statistical information in the same format for the officer-involved shootings since 1992, we learned not only that no such information had been compiled, but that virtually none of the numerous PPB executives and managers contacted about the 1992 report had any recollection of it (even when shown a copy). Pursuing whatever statistical information the PPB might have for officer-involved shootings since 1992, we learned that the only data that existed was case-by-case information kept on a Detective Division database. At least as far as anyone at the PPB could determine, no one had analyzed officer-involved shooting data since 1992.

In May 2003, shortly after the PPB had finished providing us with the little officer-involved shooting data it had, another high-profile death occurred — that of Kendra James.[231] At a public forum in July, 2003 the PPB distributed data concerning officer-involved shootings from 1993 through mid-2003.

The Bureau's openness about officer-involved shooting data in response to concern in the community about these two high-profile shootings was commendable. What we see as a problem is that the PPB was not doing anything with these data between these two events. Studying history is a way to avoid repeating it.

Recommendation 8.1: The PPB should proactively study its data on officer-involved shooting and in-custody-death incidents to assist its efforts to prevent avoidable shootings and deaths.

II. Data Collection

From the inception of this project — before PARC entered into a contract to perform this study — identification of the cases to be reviewed was a challenge. When

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[231] Kendra James was a 21-year-old woman who tried to flee a police traffic stop by driving away from the scene. An officer who had partially entered her car in an attempt to stop her from fleeing fired one shot, killing her.

the Independent Police Review Division (IPR) of the City Auditor's office asked the Detective Division to identify all officer-involved shooting cases between January, 1997 and June, 2000, the Division reported that its database showed that there were 27 such cases during that time period. This turned out to be incorrect: in October and November, 2002, IPR was able to identify five additional shootings during the relevant time period that did not appear in the Detective Division database. IPR identified two of these cases by searching *The Oregonian*'s archives, and three more through data provided by Portland Copwatch.[232] Identifying the two in-custody deaths we reviewed was similarly challenging.

When PARC requested all the PPB's statistical information on officer-involved shootings from 1992 to the present, our request was routed to the Detective Division. In April, 2003, we were provided with data on what was represented to be all the officer-involved shootings from 1992 through 2000. Comparing the data we received to the 32 shooting cases we were reviewing, we discovered that four cases we were reviewing were not included among the data provided us. All four missing cases were from 1997. Three of them were among the five cases not reported to IPR initially. The fourth involved an incident in which an officer was killed.

Part of the problem is incomplete data entry. Four of the five cases overlooked by the Detective Division in response to IPR's original request occurred during the first seven months of 1997, suggesting a particular data entry problem during that time period.

An additional problem is that there is no "officer-involved shooting" or "in-custody death" field in the Detective Division's database. Thus, to identify these types of

[232] Neither in this instance, nor in any other one discussed in this chapter, did we perceive any effort to deliberately withhold data from IPR or PARC.

cases, surrogate characteristics have to be queried, and then the sought cases need to be finally identified through human intervention.[233]

Recommendation 8.2: The PPB should develop procedures and systems to accurately and completely capture and aggregate data on officer-involved shooting and in-custody death incidents in a manner that facilitates analysis of those data.

III. Preservation of Records

In several places earlier in the report, we have dealt with the need for the PPB to create appropriate records. In Chapter 3 we discussed the importance of uniform creation of use of force reports. In Part II of Chapter 5 we discussed at length the need for all investigative information gathered to be made part of the Bureau's official files, rather than be placed in a detective's "personal file." In Chapter 6 we discussed the need for documentation of the Review Level Committee's proceedings, concerns, and recommendations.

We now address the issue of preserving records relating to officer-involved shooting and in-custody death cases, once those records have been created. We found in reviewing the investigative files that many records were missing. Two key categories of records — audiotapes (*e.g.*, recorded radio or 911 broadcasts or tapes of interviews) and detectives' "personal files" — seemed to be missing more than other types of records. Of the 34 cases we reviewed, 74 percent lacked any detective's files and 53 percent lacked any tapes. Many of the remaining files had some but not all of the tapes or detectives' files that had originally been created.

We subsequently learned that these two categories of records were often missing because the PPB did not require that they be preserved. We learned that audiotapes were released for reuse in new cases — apparently to spare the Bureau the expense of

[233] This absence of useful fields is not unique to the type of cases we are studying. As discussed in Chapter 3, the PPB does not collect use of force data in a way that allows easy analysis.

purchasing new tapes. We also learned that detectives were allowed to use their own discretion regarding their "personal files" from investigations, and consequently, many files were discarded after all legal proceedings relating to the case had been concluded.[234]

The Police Bureau's Records Retention and Disposition Schedule[235] requires that records relating to officer-involved shootings and in-custody deaths be retained for periods that range from one year to indefinitely. The retention periods often depend on the nature of the crime involved. For instance, detectives' case envelopes, also known as working files, must be retained permanently for a homicide, 21 years for sex crimes, 10 years after the last action in the case for felonies, five years after the last action for all other cases.[236]

In light of the seriousness of officer-involved shooting and in-custody death cases, and their relatively infrequent occurrence (fewer than ten a year, on average), it seems desirable to retain all records on these types of cases for at least 25 years — unless other applicable provisions require longer retention. Numerous other law enforcement agencies, including the Los Angeles County Sheriff's Department, and the Los Angeles, San Diego, San Jose, Las Vegas, Miami-Dade, Tampa, and Phoenix police departments, maintain such records indefinitely.

Recommendation 8.3: The PBB should retain all records related to officer-involved shooting and in-custody death incidents for at least 25 years. Any otherwise

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[234] The PPB has recently informed us that pending a permanent policy on disposal of detectives' files, investigators have been directed to retain all records relating to officer-involved shootings. The Detective Division has also taken measures to ensure the uniform processing of records and evidence by investigators.

[235] The Portland City Auditor's office has published this schedule on its website. See http://www.portlandonline.com/auditor/index.cfm?&a=8473&c=27199

[236] *Id.,* at § 8005-01.

applicable provision that requires longer retention than the period set for officer-involved shooting and in-custody death records should continue to be controlling.

IV. Maintenance and Cataloguing of Records

Our experience in this project was that, among the records that the Bureau creates and preserves, there are many records that cannot be found — because the methods of storing them need to be improved, because of personnel turnover, and because of lack of wide knowledge of what records are kept where.

This point may be illustrated by examples of the difficulties we encountered. In October, 2002, shortly after we began work on this project, we provided the PPB with a detailed request for various types of records relating to the cases we were reviewing. Among the items requested were all photographs taken, and videotapes made, in connection with the identified cases. By December, the PPB had produced numerous boxes of materials and informed us that, having no more records to produce, it had complied with our document requests.

In March, 2003, a PARC staff member wrote IPR an e-mail expressing concern about the disposition of tapes and detectives' files. On Friday, July 4, articles appeared in *The Oregonian* and the *Portland Tribune* discussing the contents of that e-mail. On Monday, July 7, an employee of the PPB's photo lab, having seen the news reports, informed the Bureau's public information officer, that the PPB's Identification Division possessed numerous photographs and videotapes relating to the cases PARC was studying. It turned out that the Identification Division was holding approximately 5,000 photographs and 30 crime scene videotapes pertaining to the 34 cases PARC was reviewing. We arranged to have those previously unproduced photographs and videotapes sent to us, and we reviewed them in late July — nearly nine months after we had first requested the materials.

In a similar vein, the PPB's attempt to track down what few documents existed concerning the Review Level Committee's assessment of officer-involved shooting cases was marked by delay and uncertainty. Citing staff turnover and poor record-keeping systems, the Personnel Division took more than six months to locate the few records it ultimately produced to us. Even then, statements contained in the records that were produced and information provided to us in interviews strongly suggest that additional records might be misfiled somewhere in the Personnel Division or its archives.

While misplaced files are better than no files, the PPB needs to reform its record cataloguing and storage practices.

Recommendation 8.4: The PPB should create procedures and systems that allow it to locate whatever records it possesses.

V. Records for Future Reviews

The ordinance[237] that authorized this study also authorized future follow-up reports on an annual basis, as other officer-involved shooting and in-custody death files become "closed" — *i.e.*, not subject to further legal proceedings. Steps can be taken now to facilitate those future annual reviews.

OFFICER-INVOLVED SHOOTING CLAIMS

As standard procedure a "potential" claim will be set up on all officer-involved shootings.

The following information will be forwarded to the Bureau of Risk Management by the Police Bureau Police Liability Manager as soon as the documents are available:

- All Police Reports and Special Reports related to the incident
- Interview transcripts and copies of the tapes
- BOEC printout and tapes both dispatch & call taker
- PPDS/LEDS printout on potential claimant/plaintiff
- Mug shot of potential claimant/plaintiff
- Background reports on the potential claimant/plaintiff
- Copies of any videos or photographs connected to the case (crime scene, injury photos including victims/police officers, property damage, autopsy if fatal, etc).
- Any Post-Investigation Reports on the Use of Deadly Force (After-Action)
- Any other internal memos regarding the shooting
- Status-updates on any criminal charges filed
- Status/updates on Grand Jury proceedings
- Confirmation of any LEMLA payments made

Risk Management will order the following:

- EMS reports connected with incident
- Medical Examiners report if fatality

If a formal claim or litigation is filed, the following additional information/documents will also be provided by Police Liability:

- Personnel file of officers involved
- IAD complaints/findings/files
- Responses to Request for Production such as GO's/Police Bureau Policies and Procedures

Risk Management and/or the City Attorney's Office will request/obtain the following:

- Medical bills
- Medical reports
- Wage loss verification or pecuniary loss to the estate if fatality
- Additional background, courthouse checks, index, surveillance with private investigator, witness statements, etc .

Source: Portland Risk Management office

[237] Ordinance No. 176317, effective April 12, 2002.

As discussed above, the PPB, PARC, and IPR spent extraordinary amounts of time and resources tracking down records relevant to the 34 cases PARC was asked to study. The PPB's inability to locate and produce some documents in a timely fashion delayed this report by several months. The passage of time makes records harder, rather than easier, to locate. In the normal course of events, the records that are needed to review the files after they become "closed" are duplicated for distribution to other parts of the PPB, the District Attorney's office, City Risk Management, and the City Attorney's office. If a copy of the records needed for a review were sent to IPR at the same time that they were being distributed inside or outside the PPB, the extra effort of making one more would be minimal, and the need to locate these files later would be obviated. Even if the needed records were not otherwise being duplicated, copying them and sending them to IPR at a time when their existence and location are fresh in people's minds will realize much more complete files at much less effort.

In obtaining information from the City's Risk Management office, we were provided with a list that an enterprising past employee had drawn up, cataloguing the documents that Risk Management should obtain on any officer-involved shooting claim. While the list — a re-creation of which is set forth on the preceding page — was not an official office protocol, it impressed us as an excellent list of the records that any reviewer would want to effectively review an officer-involved shooting case. The list seems equally applicable to in-custody death cases.

By obtaining these records as they were generated, or obtained, by others already working on the case, IPR would compile a comprehensive duplicate file ready to be reviewed at the appropriate time. In the meantime, IPR would store those records in a secure location. Because the PPB has historically averaged fewer than ten officer-involved shooting and in-custody death cases a year, storing the files for two to three years until they are ready for outside review should not be a problem.

Recommendation 8.5: IPR, in consultation with the PPB, should create procedures to obtain the records needed for future reviews of officer-involved shootings and in-custody deaths on a reasonably contemporaneous basis. IPR should store those records until needed for the review.

VI. Recommendations

Recommendation 8.1: The PPB should proactively study its data on officer-involved shooting and in-custody-death incidents to assist its efforts to prevent avoidable shootings and deaths.

Recommendation 8.2: The PPB should develop procedures and systems to accurately and completely capture and aggregate data on officer-involved shooting and in-custody death incidents in a manner that facilitates analysis of those data.

Recommendation 8.3: The PBB should retain all records related to officer-involved shooting and in-custody death incidents for 25 years. Any otherwise applicable provision that requires longer retention than the period set for officer-involved shooting and in-custody death records should continue to be controlling.

Recommendation 8.4: The PPB should create procedures and systems that allow it to locate whatever records it possesses.

Recommendation 8.5: IPR, in consultation with the PPB, should create procedures to obtain the records needed for future reviews of officer-involved shootings and in-custody deaths on a reasonably contemporaneous basis. IPR should store those records until needed for the review.

The Portland Police Bureau's Response to PARC's Recommendations

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City of Portland
1221 SW 4th Ave, Room 140
Portland, OR 97204

Dear Mr. Blackmer:

I have carefully reviewed the 2003 Review of Officer-Involved Shootings that was conducted by the Police Assessment Resource Center (PARC). My review consisted of thoroughly reading the report and gaining input from the senior leaders of the Portland Police Bureau. In addition, I asked Bureau managers to completely dissect this report and compare all of its recommendations with current Bureau Directives and methods of operation.

The PARC report represents a lot of hard work, and it is a substantial effort that evaluates the investigation of officer-involved shootings from January 1997 to June 2000. Not surprising, I found many of the issues brought forth in the report to be generally consistent with my ongoing discussions with other Chiefs of Police of the nation's major cities.

The Bureau received 89 recommendations in this report, and I agree with the bulk of them—92 percent. In fact, of these recommendations, I agree with 40; agree in part with 13; and disagree with only 8.

I am very pleased, however, to highlight that 28 of the recommendations in this report already have been implemented in the Portland Police Bureau. As you know, this report concludes in first half of the year 2000. Over the last three-and-a-half years, the Police Bureau, which is dedicated to continual improvement, has made changes through its consistent organizational enhancement. Because of this improvement process, these 28 recommendations were already focused on by the senior leadership of the Portland Police Bureau and changes were implemented prior to receiving this report.

It should be made perfectly clear that some of the recommendations that are not currently in place, but that I have agreed to, will require substantial budgetary support at a time when the Bureau has undergone four years of budget cuts. Accountability, for example, is a solid principle, and every police agency should have a dedicated quality assurance or audit and inspections effort. In fact, the Police Bureau implemented such a program in 2000, but in order

to preserve the core functions of the Bureau in the face of budget cuts, we had to eliminate the Inspection and Control Unit and its staff last year.

In addition, budgetary cuts have gravely affected the Police Bureau's amount of training staff, training hours and limited access to area training facilities. The Police Bureau's current budget deeply impacted the number of officers on the street and the training of all Police Bureau members.

Finally, it should be emphasized that by endorsing the recommendations, I do not in any way depreciate the competence or commitment of investigations, principally those of the Detective Division, whose work is exemplary and whose homicide clearance rate is enviable. In addition, Homicide Detectives should not be unfairly criticized for not conducting internal reviews, that up until this time they were not tasked to do.

From here, we will take the PARC report and its recommendations to the Community Policing Organizational Review Team (CPORT) that is currently meeting. CPORT, which is made up of community members and police, will also review these recommendations and channel them into their own organizational review efforts. For the next budgetary cycle, I will bring the identified areas that have been designated to be implemented as an add package. I will also prepare two follow-up reports for the Mayor and City Council, one six months from now and one a year from now describing actions taken.

Every organization, however, no matter how committed its people, has opportunities for growth and adaptations based on sound suggestions for improvement. The PARC report gives us a solid framework for meeting our community policing goals, especially those pertaining to bettering the police and community partnership and continually improving each of our processes.

Very truly yours,

MARK A. KROEKER
Chief of Police

cc: Mayor Vera Katz

Recommendation 3.1: The PPB should add a preamble or mission statement to its written deadly force policy, underscoring the Bureau's reverence for the value of human life and its view that deadly force is to be used only where no other alternatives are reasonably available.

PPB Response: *We agree with the recommendation. The Bureau currently states its reverence for the value of human life in our Mission Statement. We will staff the concept to incorporate a preamble to the deadly force policy.*

Fiscal Impact: None

Recommendation 3.2: The PPB should expand its written deadly force policy to provide that certain uses of force, such as strikes to the head or other vital areas with impact weapons, may not be used unless the officer is justified in using deadly force.

PPB Response: *We agree with the concept. Bureau policy and training covers this aspect in Directive 1030.00 of the policy and procedure manual.*

Fiscal Impact: None

Recommendation 3.3: The PPB should revise its deadly force policy to prohibit officers from using deadly force to stop a fleeing felony suspect unless they have probable cause to believe that the suspect (1) has committed an offense involving the actual or threatened infliction or threat of serious physical injury or death, and (2) is likely to endanger human life or cause serious injury to another unless apprehended without delay. In addition, the policy should make clear that even in those circumstances, deadly force should not be used where (1) other means of apprehension are reasonably available to the officers, or (2) it would endanger the lives of innocent bystanders.

PPB Response: *We agree with the recommendation.*

Fiscal Impact: None

Recommendation 3.4: The PPB should consider whether it would be appropriate to revise its written deadly force policy to expressly require officers to refrain from taking actions that unnecessarily lead to the use of deadly force.

PPB Response: *The Bureau will take the recommendation into consideration and seek information from other agencies that employ such a policy.*

Fiscal Impact: None

Recommendation 3.5: The PPB should revise its deadly force policy to clearly articulate when officers may draw or point their firearms and when they should re-holster them. In addition, the PPB should require officers to report in writing each instance in which they draw and point a firearm at another.

PPB Response: *Given the limitless variables in police encounters, the recommendation to establish policy in regards to when an officer may draw or point their firearm is not practical. However we will evaluate establishing a policy that requires articulation in a report.*

Fiscal Impact: None

Recommendation 3.6: The PPB should require its officers to record their use of force on a separate Use of Force Report. The PPB should use the information from these reports to analyze and manage its officers' use of force. The PPB should also log and track information from such reports in its early warning system.

PPB Response: *Currently, the Bureau requires officers to document in a report any use of force from handcuffing to the use of deadly force. We will study the concept of developing a tracking system for our early warning system.*

Fiscal Impact: Yes.

Recommendation 4.1: The PPB should replace its current Homicide-only model of investigating officer-involved shootings and in-custody death cases with a broader, multidisciplinary approach, such as the Internal Affairs Overlay Model or the Specialist Team Model used by most major law enforcement agencies — with the Los Angeles Sheriff's Department and Washington, D.C. systems serving as examples of best practice.

PPB Response: *We are open to a model that meets organizational and community needs. Two Assistant chiefs, a Deputy City attorney and the PPA President recently visited the Phoenix Police Department to study their IA overlay model. We will continue to examine best practices from other agencies through our Community Police Organization Review Team (CPORT) and will have recommendations to the Chief, Mayor, City Council and Community by early December.*

Fiscal Impact: Significant

Recommendation 4.2: The PPB should revise its investigative policies regarding firearms discharges at animals and non-injury accidental discharges to require supervisors arriving at the scene to immediately notify the PPB's deadly force investigation unit of the incident. The deadly force unit

should either respond to the scene and take over the investigation, or be required subsequently to review the chain of command's completed investigation for completeness and objectivity.

PPB Response: *Currently all firearms discharge incidents are reviewed by both the chain of command of the involved member, and by the review level committee. We will examine the concept of an additional layer of review.*

Fiscal Impact: Yes

Recommendation 4.3: The Bureau should revise its policies to make clear that investigators should *always* strive to obtain a contemporaneous, tape-recorded interview of involved officers. Such a policy would not only ease doubts about officer collusion, but place officers and civilians on the same footing. In addition, in those cases where an officer declines to provide a contemporaneous interview, investigators should be required to thoroughly document their efforts to obtain the interview, including (1) when the request was made, (2) to whom it was directed, and (3) the reason(s) for the declination.

PPB Response: *We have been in discussion with the PPA for the past several months to determine a timeline in which the initial interview will take place. We will endeavor to ask the involved officers at the onset of the investigation to participate in a voluntary interview and will document such efforts in the case file.*

Fiscal Impact: Yes

Recommendation 4.4: The PPB should meet with the leadership of the police unions to work out procedures for taking voluntary statements from involved officers in the hours immediately following a shooting or in-custody death incident. Interviews would not be conducted until after the officers have been given an opportunity to consult with a lawyer and/or union representative. The unions should encourage involved officers to provide investigators with contemporaneous statements, and likewise should encourage the lawyers they furnish to their members to facilitate such prompt statements.

PPB Response: *We agree with the recommendation. Refer to response to recommendation 4.3.*

Fiscal Impact: Yes

Recommendation 4.5: The PPB should study the Phoenix system of obtaining contemporaneous statements, in which all involved or witness officers are ordered to speak to Internal Affairs investigators no later than a few hours after the deadly force or in-custody death incident, regardless of whether they have already given a voluntary statement to Homicide investigators. The IA

interview, which is walled off from Homicide and the District Attorney, is used solely in connection with the agency's administrative and tactical review of the incident.

PPB Response: *As stated previously, we have sent a team to Phoenix to observe their process and interview key decision-makers. Phoenix PD provided extensive access to their training and investigative processes. The team was also able to observe a Use of Force Board as it reviewed, deliberated and provided a finding on an officer's use of deadly force.*

Fiscal Impact: Yes

Recommendation 4.6: The PPB should issue a policy expressly forbidding all officers who participated in or witnessed an officer-involved shooting or in-custody death from discussing the incident with any person (including other involved or witness officers) other than their immediate supervisor, unit commanding officer, union representative, attorney, a medical or psychological professional, and PPB investigators until they have completed comprehensive, taped interviews in the criminal and, if needed, administrative investigations. In discussing the incident with their immediate supervisor or unit commanding officer during this period, officers should provide only that information necessary to secure the scene and identify the location of physical evidence and witnesses.

PPB Response: *We agree with the recommendation. We are developing a communication restriction policy to be delivered to the involved member by Detective Division command.*

Fiscal Impact: None

Recommendation 4.7: The PPB should issue a policy forbidding all officers from volunteering or communicating any information to involved or witness officers before the deadly force investigation has been completed. In addition, just as a judge may order jurors to avoid media and other discussions of a pending case, so too should the PPB issue a policy directing involved or witness officers to avoid exposure to other accounts of the incident (even if unsolicited) until they have provided investigators with a comprehensive, tape-recorded statement. In addition, the PPB should require its investigators to thoroughly cover in each officer interview what information the officer had received from other officers or outside sources.

PPB Response: *We are exploring this recommendation and will tie any change into what is recommended under 4.6.*

Fiscal Impact: None

Recommendation 4.8: The PPB should require that supervisors arriving at the scene of an officer-involved shooting or in-custody death incident ask each officer at the scene what, if any, discussions regarding the incident have occurred prior to the supervisor's arrival. The supervisor should then brief investigators immediately after they arrive at the scene concerning the answers to those inquiries.

PPB Response: *Agree with the recommendation, however this may be addressed better by detectives upon first arrival to the scene to keep the uniform supervisors out of the mainstream of the investigation.*

Fiscal Impact: None

Recommendation 4.9: The PPB should require that involved and witness officers be physically separated immediately after the scene has been secured, and that the officers remain sequestered (*i.e.*, unable to communicate with each other) until they have submitted to a comprehensive, taped interview by investigators.

PPB Response: *Agree with the recommendation, however the communications restriction placed upon the involved members should take the place of sequestration after the involved member leaves the scene.*

Fiscal Impact: None

Recommendation 4.10: The PPB should memorialize in its policies the requirement that members of the TIC Team — and any other officer not charged with securing or investigating the scene of an officer-involved shooting or in-custody death incident — remain outside of the crime scene absent express authorization from on-scene PPB investigators.

PPB Response: *PPB agrees with the recommendation and will strengthen TIC Team policies to ensure compliance with the recommendation.*

Fiscal Impact: None

Recommendation 4.11: The PPB should memorialize in its policies a rule expressly prohibiting members of the TIC Team — and any other officer not charged with securing or investigating the scene of an officer-involved shooting or in-custody death incident — from discussing the incident with involved or witness officers until the officers in question have submitted to a comprehensive, taped interview with PPB investigators.

PPB Response: *TIC Team members are currently instructed not to engage in discussions with involved officers about the incident specifics. PPB agrees this policy should be enforced through specific SOP's for TIC Team members.*

Fiscal Impact: None

Recommendation 4.12: The PPB should revise its deadly force policy to ensure that all persons who witnessed an officer-involved shooting or an in-custody death are interviewed on tape by investigators. The PPB should specifically eliminate its policy granting Homicide the discretion to forego interviews of witness officers and rely instead on written reports. Transcripts of all interviews should be included in the case file.

PPB Response: *We agree in concept. We will examine best practices used by other organizations in the country. Exceptions to taped statements are necessary and must be authorized by the Detective Division Commander. All exceptions will be documented in a report.*

Fiscal Impact: Yes

Recommendation 4.13: If a civilian refuses to submit to a taped interview, investigators should (1) not begin the interview until the witness has signed a form acknowledging that he or she has refused to be interviewed on tape; and (2) present the civilian with a written copy of the investigator's summary of the interview and allow the citizen to review and sign the investigator's summary for accuracy. The civilian 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/amended witness summary should be included in the investigative file.

PPB Response: *This is an unusual request. We would like to know what other agencies employ this proactive technique and be provided with examples of the policy and work product to explore and examine further.*

Fiscal Impact: Yes

Recommendation 4.14: PPB investigators should video- or tape-record all scene walk-throughs with involved or witness officers. Transcripts of all taped interviews or walk-throughs should be included in the case file.

PPB Response: *The Bureau requests further clarification. We would like to see what other agencies do with regard to this recommendation. The Identification Division has video taped major crime scenes such as suspicious deaths, homicides, and officer involved shootings since 1989. The equipment is available to conduct such tasks.*

Fiscal Impact: Yes.

Recommendation 4.15: The PPB's policy and practice of conducting untaped "pre-interviews" of officers or civilians should be eliminated.

PPB Response: *We agree with the recommendation.*

Fiscal Impact: Yes

Recommendation 4.16: The PPB should improve the already-useful existing Deadly Force Interview Checklist by adding policy and tactical questions, including: (1) whether the officers can think of (a) alternative approaches that might have minimized risk to themselves and others, and (b) potential improvements in PPB training; (2) a description of when and why the officers decided to (a) draw their guns; (b) point their guns; or (c) lower or re-holster their guns; (3) describing the grip and shooting stance used by the officers, including gun/flashlight technique; (4) indicating whether the shots were sighted; (5) describing the availability and use of cover and concealment; and (6) identifying distances from suspects with weapons other than guns, and opportunities for tactical retreat.

PPB Response: *The use of Internal Affairs investigators to examine the training and policy issues in a deadly force incident is a model we will review thoroughly in the CPORT process. There would be a significant resource impact to training and staffing this additional function within IA. Open to modification of our interview checklist. Many questions can be/should be asked by Detectives during the initial investigative interviews.*

Fiscal Impact: Yes

Recommendation 4.17: The PPB should also issue a policy requiring investigators to cover all areas on the modified interview checklist in all interviews.

PPB Response: *We agree with the recommendation.*

Fiscal Impact: None

Recommendation 4.18: The PPB should prepare an Interview Checklist, similar to the Deadly Force Interview Checklist, to be used during in-custody death and serious force investigations.

PPB Response: *We agree in regard to in-custody death investigations. The organization is open to recommendations about the investigation of serious force applications. CPORT will examine the current policies regarding serious use of force matters.*

Fiscal Impact: Yes

Recommendation 4.19: The PPB should establish policies that ensure that each officer who was involved in or witnessed an officer-involved shooting or in-custody death incident does not participate in a Critical Incident Stress Debriefing (CISD) meeting prior to submitting to a comprehensive, tape-recorded interview in the investigation of the incident.

PPB Response: *Agreed. It has been past practice for the Bureau to conduct such debriefings after the investigation is complete.*

Fiscal Impact: None

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.

PPB Response: *We agree with recommendation. This is already in PPB policy, however it needs to be consistently enforced.*

Fiscal Impact: No

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.

PPB Response: *We agree with the recommendation. An audit function should also be introduced to ensure accountability. Within the past year, Senior Criminalists of the Identification Division have developed a checklist of tasks that need to be performed and a general direction and chronological order in which the tasks should be performed.*

Fiscal Impact: Yes

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.

PPB Response: *We agree with the recommendation. The Identification Division recognized this shortcoming, so for over the course of the past 2 years, the Identification Division has equipped 2 "Homicide" vans with the equipment necessary for detection and recovery of evidence, and supplies necessary for proper collection and packaging of evidence. We are continuously searching for new technology to upgrade our current capabilities.*

Fiscal Impact: Significant

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 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.

PPB Response: *We will examine new technology as to gunshot residue testing of involved person's hands, however the Oregon State Police Crime Lab, which conducts our forensic testing, advised such tests are inconclusive. The OSP crime lab routinely conducts gunshot residue tests on clothing and objects to determine proximity, etc.*

The Identification Division has been researching GSR kits that can be used in the field for the past year. Our study will continue until adequate data can be obtained for recommendations.

Fiscal Impact: Yes.

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.

PPB Response: *We agree with the recommendation. The Identification Division with the outfitting of the "Homicide" vehicles currently has 3 methods of collecting bullet trajectory evidence. We are currently researching better technology to ensure more accurate collection of such information. See response to 5.3.*

Fiscal Impact: Yes

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.

PPB Response: *We agree with the recommendation. See responses to recommendations 4.16, 4.17 and 4.18.*

Fiscal Impact: Yes

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.

PPB Response: *We agree with the recommendation. This is current practice by investigative detectives.*

Fiscal Impact: Yes

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.").

PPB Response: *We agree with the recommendation.*

Fiscal Impact: Yes

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.

PPB Response: *We agree with the recommendation.*

Fiscal Impact: No

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.

PPB Response: *We agree in concept with the recommendations regarding training and accountability. See responses to 4.11 and 4.14. We already interview emergency medical personnel including paramedics, fire/rescue personnel and emergency room/hospital staff. However we do not usually conduct those interviews on tape. We do collect medical records as necessary that are produced by the above persons. We do not formally interview the pathologist/medical examiner. Those professionals are part of our investigative team and we rely on meetings, discussions and their formal report as to their examinations. For instance, the medical examiner tape records the autopsy examination and provides a comprehensive report as a result of that exam.*

Fiscal Impact: Significant

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.

PPB Response: *We agree with the recommendation. Portions of the recommendation were adopted prior to the production of the PARC report.*

Fiscal Impact: Yes

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.

PPB Response: *Decisions on this recommendation will be made as a review process is developed through CPORT.*

Fiscal Impact: Yes

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.

PPB Response: *We agree with the recommendation in regards to page numbering and providing an index. As to an investigator's log, we will examine other organizations for determining the best practice.*

Fiscal Impact: Yes

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.

PPB Response: *We agree with the recommendation, however we will and do follow city auditor's guidelines as to archiving.*

Fiscal Impact: No

Recommendation 5.15: The City of Portland 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.

PPB Response: *The inclusion of community members on a Use of Force Board (similar to the Phoenix model) would provide for an external review and greater transparency in the review process. If we were to include an IA overlay model with excellent training and protocols, it could provide the same in-depth analysis and investigation of policy issues and tactical decisions.*

Fiscal Impact: Yes

Recommendation 6.1: The PPB policies relating to reviews of deadly physical force — both after action reports and Review Level Committee — should be explicitly extended to in-custody death incidents.

PPB Response: *We agree with the recommendation.*

Fiscal Impact: Significant increase for investigative costs.

Recommendation 6.2: The PPB should ensure that after action reports are completed in all officer-involved shooting and in-custody death cases, and that unit commanders are held accountable if the reports are not completed in a timely fashion.

PPB Response: *PPB agrees with the recommendation and will review current policies and procedures to ensure compliance.*

Fiscal Impact: Minimal

Recommendation 6.3: The PPB should enforce its policy that requires unit commanders, rather than their subordinates, to prepare and sign after action reports in deadly force cases.

PPB Response: *PPB agrees that unit commanders are ultimately responsible for the after-action reports and their timeliness. The Bureau does believe there is merit in having Lieutenants and even Sergeants prepare after-action reports for the commander's signature as a means of facilitating accountability for all supervisory persons with responsibility for an incident. In those cases, the commander can still prepare a cover memorandum detailing their specific findings and recommendations.*

Fiscal Impact: Minimal

Recommendation 6.4: The PPB should create a model after action report — from an actual or a hypothetical case — to demonstrate to unit commanders both the form and type of analysis that such reports should employ.

PPB Response: *PPB agrees that after-action reports should follow a more standardized format, but will need to ensure this does not become a "check the box" type of format, that would hamper independent and critical analysis of the event.*

Fiscal Impact: Minimal

Recommendation 6.5: The PPB should ensure that after action reports rely on the facts developed by the investigation of the incident (unless the unit shows that those facts are erroneous or incomplete), and that copies are distributed to the detectives who investigated the incidents and their commanding officer.

PPB Response: *PPB agrees persons preparing after-action reports should have all investigation information available prior to the preparation of the report.*

Fiscal Impact: Minimal

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.

PPB Response: *If other recommendations, to which we have agreed are implemented, this recommendation will stand with them.*

Fiscal Impact: Minimal

Recommendation 6.7: The PPB should revise Section 1010.10 to make the unit commander a non-voting member of the Review Level Committee when it reviews officer-involved shootings, other deadly force cases, and in-custody death incidents.[1]

PPB Response: *PPB disagrees with the recommendation. As part of the Bureaus focus on accountability, the Bureau believes the Unit Commander should be required to vote on record, as to the appropriateness of the use of force. A vote in the review level process is far more significant and carries a higher standard of responsibility than an initial recommendation in an after-action.*

Fiscal Impact: N/A

Recommendation 6.8: A civilian from outside the Bureau should be made a voting member of the Review Level Committee. The outside committee member should be chosen in a manner decided by the City's elected officials.

PPB Response: *We disagree with recommendation as to form. The Review Level Committee is for discipline review. An independent civilian review already exists in the form of the Independent Police Review (IPR). However, CPORT is currently studying the Phoenix model which includes civilian members on their discipline review board.*

Fiscal Impact: Minimal

[1] The Review Level Committee also considers disciplinary matters that have been investigated by Internal Affairs. Since the unit commander is playing a fundamentally different role in such cases — a role that does not present the same inherent conflicts of interest — there remain good reasons for allowing the unit commander to remain a voting member of the committee on such cases. We thus limit this recommendation to the types of cases that are the subject of this study, as well as other deadly force cases, which raise the same considerations.

Recommendation 6.9: The PPB should amend its policy and its practice to make the commanding officer of the unit conducting administrative investigations of officer-involved shootings and in-custody deaths, and the commanding officer of the Training Division, non-voting members of the Review Level Committee.

PPB Response: *Agree with recommendation. The Commander of the administrative investigations unit and the Commanding Officer of the Training Division have never been voting members of the Review Level Committee.*

Fiscal Impact: None

Recommendation 6.10: All officer-involved shooting and in-custody death incidents should be presented to the Review Level Committee. The PPB should develop a tracking system to ensure that all such incidents are presented.

PPB Response*: Agreed, but the presentation will be to a new Use of Force Review Board to be constituted.*

Fiscal Impact: Minimal

Recommendation 6.11: PPB policy should be amended to require that full written findings be provided to the Chief to explain and document each Review Level Committee determination on officer-involved shooting and in-custody death cases.

PPB Response: *Agreed, however PPB will research current practices with other agencies and review those findings with the City Attorney's Office prior to recommending implementation of any change to the current practice.*

Fiscal Impact: Minimal

Recommendation 6:12: The PPB should develop procedures for the Review Level Committee that require members to vote based on their best judgment of the relevant facts and circumstances and that encourage dissent when appropriate.

PPB Response: *Agreed. Such will be the case with the Use of Force Review Board to be constituted. It is not the current practice or policy that all members of the Review Level Committee be unanimous in their recommendations.*

Fiscal Impact: None

Recommendation 6.13: The investigators who conduct the administrative investigations should take the lead in presenting officer-involved shooting and in-custody death cases to the Review Level Committee.

PPB Response: *We disagree with the recommendation. Commanders who sign After-Action reports, and who have accountability should make the presentation to the Board. Presentation of the case will be reviewed as part of the overall review of the proposed changes to the current Review Level Committee system. When appropriate, as in the most recent officer involved shooting case presented at Review Level, information was presented to the Review Level Committee by the investigating officers.*

Fiscal Impact: Minimal to moderate, depending on the complexity of the investigation, number of investigators involved and amount of evidence to be presented.

Recommendation 6:14: The administrative investigators should present a full file — regardless of the form of the evidence, and specifically including video and audiotapes and photographs — to committee members in advance of the committee meeting, and should likewise present all evidence they deem pertinent to the Review Level meeting, regardless of the form that evidence takes.

PPB Response: *PPB agrees that all relevant evidence should be provided to the Review Level Committee. It should be noted that members of the Review Level Committee have always had the ability to request additional photographs or other evidence not included in the information packets currently provided to committee members.*

Fiscal Impact: Minimal to moderate, depending on the complexity of the investigation and the amount of evidence to be presented.

Recommendation 6.15: Before a meeting of the Review Level Committee on an officer-involved shooting case or an in-custody death incident, the Training Division should prepare a written analysis of the tactical and training issues involved and circulate that analysis to committee members in advance of the meeting.

PPB Response: *PPB agrees that the Training Division should be an important part of the Review Level Process. We would like to look at other agency practices which includes a review of the incident by the Training Division and their participation and analysis of the incident at Review Level*

Fiscal Impact: Yes

Recommendation 6:16: The PPB should amend its policy to increase the options the Review Level Committee has for outcome determinations so that those options cover the different levels of review: legal, policy and tactical.

PPB Response: *Agree with recommendation, however will be under Use of Force Review Board.*

Fiscal Impact: None

Recommendation 6.17: The Review Level Committee should seek to obtain additional information whenever the committee determines that such information would assist it in fulfilling its responsibilities.

PPB Response: *Agree with recommendation. This is current practice and committee members have sent investigations back for further follow up or additional information (Use of Force Review Board).*

Fiscal Impact: Minimal

Recommendation 6.18: The PPB should create systems that ensure that all lessons learned — both successes and failures — are systematically identified and followed up on.

PPB Response: *Since 2001, PPB has developed a tracking system in the Personnel Division to record recommendations and training issues identified in Officer Involved Shootings and to track actions taken as a result of the recommendations. Recently, modifications were completed to the system to increase its effectiveness*

Fiscal Impact: Minimal

Recommendation 6.19: The PPB should revise its awards policy and procedures in officer-involved shooting and in-custody death cases to ensure that the Award Review Committee and the Chief are aware of all facts and circumstances relevant to the appropriateness of an award that were revealed in the investigation of the incident, in the after action report, and in the Review Level Committee proceedings.

PPB Response: *Agree with recommendation. Prior to the PARC report, a Work Improvement Team (WIT) chaired by Assistant Chief Lynnae Berg had identified the need to research and review possible modifications to the current Awards committee as it relates to officer-involved shootings.*

Fiscal Impact: Minimal

Recommendation 6:20: The PPB should revise its awards and Review Level policy and procedures in officer-involved shooting and in-custody death cases to require that the Awards Review Committee facilitator advise the Review Level Committee in writing of any information revealed in the awards review process that was not in the investigative file, the after action report, or the Review Level Committee's records. Upon receipt of notice of such new information, the Review Level Committee should consider whether to reopen its review of the incident, with or without further administrative investigation.

PPB Response: *Agree. See response 6.19.*

Fiscal Impact: Minimal

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.

PPB Response: *Agree. The Bureau strives to instill proper plan of action to be taken through training and incident debriefing. We will study the concept to add at review with the Use of Force Review Board.*

Fiscal Impact: None

Recommendation 7.2: The PPB should ensure that the incidence of communications failures during police operations is minimized.

PPB Response: *Agree. Radio operation and communication is covered in Bureau policy and in training. Consistent policy enforcement s needed.*

Fiscal Impact: None

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.

PPB Response: *Agree. The Bureau endeavors to ensure supervisory and command staff receives the necessary training for critical incident decision making. We are currently reviewing the Bureau's at scene officer in charge policy.*

Fiscal Impact: None

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.

PPB Response: *Agree. See response to recommendation 7.3*

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

PPB Response: *Agree with recommendation.*

Fiscal Impact: N/A

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

PPB Response: *Agreed.*

Fiscal Impact: N/A

Recommendation 7.7: The PPB should emphasize the relevance of supervisors' critical incident training to routine police operations.

PPB Response: *Agree. Training provided to and policy governing a supervisor's duties places great importance on overall management of operations.*

Fiscal Impact: None

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, crossfires and bystander endangerment.

PPB Response: *The Training Division maximizes the transference of skills and knowledge, and the likelihood that they will be used on the street, by using scenario-based training. By creating a training environment that replicates the real world (workplace) as closely as possible, the application of newly acquired skills and knowledge is made easier. When a new skill is learned, it requires conscious thought to recall and to implement. When the environment is familiar, the recall is faster and requires less interpretation. In short, the training should give the student a feeling of "been there, done that" when it is applied to a real life situation.*

Fiscal Impact: Yes

Recommendation 7.9: The PPB should ensure that supervisors consistently manage vehicle pursuits to a high standard.

PPB Response: *Agree. The Bureau realizes the inherent risks in vehicle pursuits. Bureau policy requires supervisory management of vehicle pursuits. Policy needs to be consistently enforced.*

Fiscal Impact: None

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

PPB Response: *Agreed. Concept covered in training.*

Fiscal Impact: None

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

PPB Response: *The Training Division currently instructs that if you don't catch the subject in the first seconds of a foot pursuit or the subject enters the "blocks" (area between houses and backyards), you should follow/monitor at a safe distance until a perimeter can be established. Once a perimeter has been established, you should do a systematic search with either canine or SERT, depending on what you know about the suspect (armed unarmed).*

Fiscal Impact: Yes

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

PPB Response: *Agree. Concept covered in training and in incident debriefing.*

Fiscal Impact: None

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

PPB Response: *Agree. Concept covered in firearm and scenario based training. Also falls under critical incident management.*

Fiscal Impact: None

Recommendation 7.14: The PPB should ensure that the incidence of endangerments to bystanders is minimized.

PPB Response: *Agree.*

Fiscal Impact: None

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.

PPB Response: *Agree. The Bureau will review current policy in regards to shooting at or from vehicles.*

Fiscal Impact: N/A

Recommendation 7.16: The PPB should take steps to minimize the risk of accidental discharges.

PPB Response: *The Training Division currently instructs recruits and officers to keep their fingers off of the trigger and out of the trigger guard until they are on target and ready to fire. This is closely watched and monitored. During training scenarios involving firearms, officers are videotaped. After the scenarios, the participating officer(s) view the videotape with an instructor to critique their actions. The critique includes firearm handling and safety.*

Fiscal Impact: N/A

Recommendation 7.17: The PPB's Training Division should reconsider its current training in maneuvers that involve weak-handed shooting.

PPB Response: *The Training Division currently instructs recruits and officers to fire and handle their firearm with their "off-hand" – handling/firing a firearm with their non-preferred hand. The instruction and practice serves two purposes: 1) In some tactical situations using the off-hand gives the officer a tactical advantage. 2) If the officers' preferred hand becomes disabled, he/she can handle/fire the firearm with the off-hand.*

Fiscal Impact: N/A

Recommendation 7.18: The PPB should abandon use of term "lethal cover" in relation to less-lethal weaponry training and deployment.

PPB Response: *We disagree. When it is determined that less-lethal is an option, the operator of the less-lethal weapon is given a cover officer who can readily use deadly force if necessary. The less-lethal operator is given this cover because he/she is encumbered with the less-lethal weapon and can not readily transition to a firearm if needed.*

In most situations each officer is responsible for their own safety. In a less-lethal situation, the less-lethal operator has reduced his/her capability to defend and protect himself or herself in a deadly force situation; therefore, they are given a cover officer who can act in that capacity if necessary. The "lethal" designator merely identifies the cover officers' capabilities. The term is widely understood by trained PPB officers, but needs to be better explained to the public.

Fiscal Impact: N/A

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.

PPB Response*: Officers are required to write a report outlining the use of less-lethal force. The report is submitted to their supervisors. The supervisors, after reviewing the incident, author an after-action report and forward it through channels to the branch assistant chief for review. The original report written by the officer is submitted to the Records Division.*

The Training Division reviews all applications of less-lethal by reading all reports of incidents in which less-lethal force is used. The review assists in determining training needs and concerns. In the future the Training Division would like to design and maintain a database to track all deployments of less-lethal weapons.
Fiscal Impact: Minimal

Recommendation 7.20: The PPB should provide all operational personnel with a radio earpiece.

PPB Response: *Agree. The Bureau strives to provide officers the equipment necessary to attain maximum officer safety.*

Fiscal Impact: Significant.

Recommendation 7.21: The PPB should establish a helicopter unit.

PPB Response: *Agree in concept. The Bureau would like to identify and implement a dedicated flight team, establish a full time air unit, and share the cost, staffing and benefits with agencies in the Portland Metropolitan area.*

Fiscal Impact: Extremely significant.

Recommendation 7.22: The PPB should ensure that CIT officers consistently exercise their specialist skills when dealing with CIT-related incidents.

PPB Response: *Agree. The Bureaus purpose of establishing the program was to ensure better response to incidents involving mentally ill individuals, to reduce the risk to officers and citizens, and to ensure mentally ill individuals received proper treatment whether it come through the criminal justice system or mental health treatment. Study to expand program.*

Fiscal Impact: Yes

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.

PPB Response: *Agree. See response to recommendation 7.22*

Fiscal Impact: Yes

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.

PPB Response: *Agree. Extensive training and Bureau policy are current. Consistent policy enforcement by management and refresher training will be reviewed.*

Fiscal Impact: Yes

Recommendation 8.1: The PPB should proactively study its data on officer-involved shooting and in-custody-death incidents, to assist its efforts to prevent avoidable shootings and deaths.

PPB Response: *PPB agrees that data collection is an invaluable tool, not only for a historical perspective, but also for the development of training, policy and procedures.*

Fiscal Impact: Yes

Recommendation 8.2: The PPB should develop procedures and systems to accurately and completely capture and aggregate data on officer-involved shooting and in-custody death incidents, in a manner that facilitates analysis of those data.

PPB Response: *Agree. See response to recommendation 8.1*

Fiscal Impact: Yes

Recommendation 8.3: The PBB should retain all records related to officer-involved shooting and in-custody death incidents for 25 years. Any otherwise applicable provision that requires longer retention than the period set for officer-involved shooting and in-custody death records should continue to be controlling.

PPB Response: *Agree. The Bureau will review recommendation with City Auditor and make necessary modifications.*

Fiscal Impact: Yes

Recommendation 8.4: The PPB should create procedures and systems that allow it to locate whatever records it possesses.

PPB Response: *Agree.*

Fiscal Impact: Yes

Recommendation 8.5: IPR, in consultation with the PPB, should create procedures to obtain the records needed for future reviews of officer-involved shootings and in-custody deaths on a reasonably contemporaneous basis. IPR should store those records until needed for the review.

PPB Response: *Agree in concept. Will review with city auditor on appropriate archiving, access and distribution of such records.*

Fiscal Impact: Yes