Report to the City of Portland on Portland Police Bureau Officer-Involved Shootings

First Report ◦ May 2012

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CITY OF PORTLAND

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

From: City Auditor LaVonne Griffin-Valade

Re: OIR Group – Review of closed investigations of seven officer-involved shootings

In the attached report, the OIR Group presents the results of their review of the closed investigations of these seven officer-involved shootings: James Jahar Perez – March 2004; Raymond Gwerder – November 2005; Jerry Goins – July 2006; Lesley Stewart – August 2007; Jason Spoor – May 2008; Aaron Campbell – January 2010; Jack Dale Collins – March 2010.

City Code chapter 3.21 established the Auditor's Independent Police Review (IPR) division in 2001. City Council subsequently strengthened that Code chapter by empowering the City Auditor to hire outside experts to review closed Police Bureau investigations of officer-involved shootings and in-custody deaths. This is the sixth such review ordered by this office and reported to the public and City Council.

As their primary focus in this particular review, the OIR Group selected incidents involving Police Bureau encounters with individuals experiencing some level of mental or emotional crisis. Another theme the OIR Group considered was communication at the scene of a critical event. At my request, the 2004 Perez case was also included in the current review because it is the oldest of the incidents eligible for expert review and because that incident generated intense community concern and contributed to the Police Bureau establishing the Use of Force Review Board.

By examining incidents that occurred over a six-year span of time, the OIR Group's report effectively establishes a historical context. This strengthens and adds to the merit of their thirteen recommendations for improvements in Police Bureau policy and tactics. I appreciate the thorough analysis and clarity in presentation of information, and would like to thank the OIR Group team members for their professionalism throughout the review. This report has significant value for my office, for City Council, for the Police Bureau, and most importantly, for the community we serve.

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Foreword

On March 28, 2004, a Portland Police officer shot and killed James Jahar Perez, an unarmed motorist, after he reached into his pocket and began to withdraw his hand. The shooting generated significant community interest and concern about the use of deadly force by the police, and raised questions about how an unarmed man who may have been attempting to comply with officers' commands ended up being shot and killed.

Almost six years later, on January 29, 2010, another Portland officer shot and killed Aaron Campbell, a reportedly distraught suicidal man who had first been struck by beanbag rounds fired by another officer and who also turned out to be unarmed. As with the shooting of Mr. Perez, the incident roiled the Portland community and reopened deep-rooted concerns about the use of deadly force by the Portland Police Bureau. After an extensive investigation, the Bureau determined that the decision to use deadly force violated policy and Chief Mike Reese moved to fire the officer. The officer appealed, and on March 30, 2012, an arbitrator issued her opinion overruling the termination decision and ordering the Bureau to reinstate the officer.

Both the Perez and Campbell shootings are notable examples of the understandable interest raised in the Portland community when a Portland Police Bureau officer uses deadly force. While law enforcement must be authorized to use deadly force in the appropriate circumstances, it is incumbent upon any progressive law enforcement agency to conduct a thorough investigation and review of these incidents because the consequences for the person shot, his family, and the community at large are so great.

This report analyzes seven Portland Police Bureau officer-involved shootings spanning the time between March, 2004 and March, 2010, each with its own issues and each eliciting different degrees of community response. Almost all share the common element of having been precipitated by the actions of an individual in mental health or emotional crisis. The commonalities do not end there, however. Many of these events raise questions about officers' ability to communicate with each other at the scene of critical incidents, to consider alternative plans, and to respond quickly and effectively when a subject has been downed by police gunfire. The benefit of reviewing multiple incidents occurring over time is that it provides a snapshot of the Portland Police Bureau's (PPB) policies and training as they evolved in response to each incident. In some cases, this evolution is notable and commendable. Others lead us – and members of the public – to question why the Bureau had not learned more from its prior shooting incidents.

Each of these shootings also provides the opportunity to evaluate the PPB's mechanisms for investigating and reviewing critical incidents, and to observe how those have changed over time. The Bureau's development in this regard has been remarkable. Quite unlike many municipalities where we have seen significant reports commissioned and then subsequently buried, the PPB has been responsive to the reports from the Police Assessment Resource Center (PARC) dating from 2003. PARC's recommendations regarding the quality of internal investigations did not go unheeded, and the result is that today the PPB conducts thorough, professional investigations into its officer-involved shootings.

The PPB's ability to use a critical incident as a springboard toward systemic reforms likewise has evolved over time. As we discuss fully with respect to each shooting, these incidents show varying degrees of internal critique and review leading to changes in policies and training. While we note deficiencies in the timeliness and quality of the internal analysis and review process throughout this report, we nonetheless find the PPB to be superior to most comparable law

enforcement agencies in the way it which it reviews critical incidents. The use of exacting Training Division analyses, Commanders' Review memos that do not shy away from difficult issues, and a Police Review Board that includes peer officers and members of the public are evidence of a Bureau willing to learn from its mistakes and to account to its public in a way that is counter to the instincts of most police agencies. The Bureau's history of opening itself to outside review and acceptance of recommendations from independent sources likewise sets it apart from many agencies.

Nonetheless, there is still room for improvement. With respect to each individual shooting, we note issues relating to the tactics employed, as well as the quality of the investigation and review process. We also identify issues common to many shootings, including delays in the interviews of involved officers, delays in the review process, inconsistent quality of the Training Division Reviews, tactical communications issues, and insufficient efforts to rescue downed suspects quickly. The investigation and review of many of these shootings happened with little real-time independent oversight, as the City Auditor's Independent Police Review division (IPR) was originally circumscribed to play a minimal role in such critical incidents. Recent modifications to the City's ordinance have strengthened IPR's responsibilities, and we believe this increased authority will add an important component to the investigative and review processes.

This report is an independent account of the covered shootings and how the Bureau investigated and reviewed each. After reviewing seven of the 18 incidents the City has requested we evaluate, it is too soon to cite trends regarding PPB officers' use of deadly force. While we identify numerous tactical deficiencies with regard to many of the incidents we reviewed, and some weaknesses with respect to the individual investigations and reviews, we observe positive efforts as well. Most importantly, we acknowledge the Bureau's willingness to be self-critical, to confront perceived deficiencies quickly and proactively, and to do so in an open and transparent way. We appreciate the PPB's cooperation and openness and look forward to an ongoing positive dialogue as we continue our work on the shootings and in-custody death we have yet to review.

This report contains three sections. Section One contains a factual summary of each of the seven shootings, along with an analysis of issues presented by each. Section Two is an analysis of themes and issues we identify that are common to all seven shootings. Section Three presents a list of all recommendations we make throughout this report.

Scope of Review

The City of Portland currently has tasked OIR Group with reviewing 17 officer-involved shootings and one in custody death involving the Portland Police Bureau that occurred from March, 2004 to January, 2011. The criteria for inclusion in this group was any officer-involved shooting or in-custody death for which the Bureau's internal investigation had been concluded by December 31, 2011 and which had not previously been analyzed by the Police Assessment Resource Center (PARC) during their review of critical incidents in 2002 through 2009. When PARC was hired by the City, the Auditor at the time limited its review to only those cases for which no litigation was pending or still possible. The result is that some of the cases we review here happened years ago. While this can be frustrating, in that some of the training and equipment issues presented in those cases clearly have been addressed by the Bureau and are no longer relevant, the large span of years presents the opportunity to examine how the PPB has evolved and either addressed or failed to address certain fundamental issues.

Rather than review 18 cases in one omnibus report, we decided to break our review down into smaller, more focused, reports. In this first report, we analyze seven officer-involved shootings. We selected one of these – the shooting of James Jahar Perez – because it occurred in 2004 and we believed the City has already waited too long for outside, independent review of that case. The remaining six cases – the shootings of Lesley Stewart, Jerry Goins, Jason Spoor, Raymond Gwerder, Aaron Campbell, and Jack Dale Collins – are grouped together here because the subjects who were shot all appeared to be in some significant mental health or emotional crisis. Because this report follows our 2010 report into the 2006 in-custody death of James Chasse, in which the Bureau's interaction with the City's mentally ill population came to a flashpoint, we believed these seven cases to be a good starting point for this project.

For this report, we reviewed all of the PPB's investigative materials for each of the seven shootings, including the Detectives' and Internal Affairs (IA) investigations, as well as grand jury transcripts in the two cases where those were available (Campbell and Collins). We also read and considered the Training Division Review and materials documenting the Bureau's internal review and decision-making process connected with each shooting. We requested and received training materials relevant to firearms training, less-lethal weaponry, and critical incident management. We also requested and received a copy of the current labor agreement between the Portland Police Association and the City.

We met with PPB executives; leaders in the Detectives, Internal Affairs, and Training Divisions; members of the Citizen Review Committee; community advocacy groups, including mental health advocates and members of the Albina Ministerial Alliance; the president of the Portland Police Association; members of Special Emergency Reaction Team (SERT) and Hostage Negotiation Team (HNT) (now renamed the Crisis Negotiation Team – CNT to better reflect its responsibilities); the civilian coordinator of the PPB's Crisis Intervention Team program; a civilian facilitator of the Police Review Board; and lawyers who have frequently represented individuals and family members in lawsuits against the police. In addition, we observed a Police Review Board proceeding for an officer-involved shooting we will review in a subsequent report, and spent half a day on a ride-along with the Bureau's Mobile Crisis Unit. Throughout our review, we received complete cooperation from PPB members and all other stakeholders who responded candidly to our questions. As called for in the review project design, we also reviewed reports and recommendations from PARC that have been prepared periodically since 2003.

Our analysis centers on the quality and thoroughness of the Bureau's internal investigation and review of each of the incidents presented. We look at relevant training and policy issues, and corrective actions initiated by the Bureau. We do not opine on whether any particular shooting, or related tactic or use of force, is within policy, nor do we criticize the actions of the individual officers involved or second-guess the Bureau's decisions on accountability and discipline. We do fault the Bureau, however, when we find issues that were not addressed or thoroughly plumbed by the investigation and review process that could have impacted the Bureau's findings on the appropriateness of the force or other tactical decision-making.

Mental Health Issues

As in any large city, police in Portland regularly encounter individuals struggling with mental health issues. The Bureau has been innovative and proactive in training its officers and partnering with the mental health care community in efforts to improve its service to the mentally ill. Following the 2006 in-custody death of James Chasse, the Bureau made a commitment to provide each of its officers Crisis Intervention Team (CIT) training. The training program focuses on police interaction with people in crisis, with a particular emphasis on those with mental illness. That training had been available on a voluntary basis beginning in

1994, with about 60 officers completing the 40-hour training each year. Within six months of Mr. Chasse's death, the Bureau had revamped its CIT program, made it mandatory for all officers, and had its more than 600 patrol-assigned officers complete the training. We noted in our 2010 report how remarkable was the Bureau's resolve to implement this program quickly.

The PPB has continued to build on this development. Among those responsible for overhauling the CIT program following Mr. Chasse's death was a psychologist who worked with Project Respond, the mobile mental health crisis response team for Multnomah County. The PPB has since hired her to work full time with the Training Division, where she is working to integrate crisis intervention and communication with individuals with mental health disorders into patrol tactics and other standard training curricula. In addition to her role as CIT coordinator, she also acts as a liaison for the Bureau to mental health groups and is a member of the Crisis Negotiation Team who responds to all callouts.

Another innovative development was the introduction of the Mobile Crisis Unit (MCU) in the spring of 2010. This unit pairs a PPB officer in Central Precinct with a Project Respond clinician with the goal of dealing proactively with mentally ill individuals whose disorder may lead them to have frequent contact with police. The MCU was introduced as a pilot project, and the Bureau is currently working on plans to make the team permanent and to expand its hours and its scope. To understand better how the MCU operates, we spent half a day riding along with the team.

The MCU responds to calls, if requested, but is more oriented toward preventing police interaction. To that end, they begin their day culling through the previous day's reports and identifying situations in which their specific tools and expertise may be useful. For example, they learned about numerous calls for service emanating from an apartment building where a mentally ill resident had been heard making vague threats, including some indication that he may have weapons. Patrol officers recognized they did not have enough evidence on which to base an arrest, and realized that confronting the suspect could unnecessarily escalate the situation. In addition, they had limited resources and time to devote to this problem. The MCU team, however, did not have these same limitations. The pair spent time developing background information on the suspect, and the mental health clinician accessed the suspect's mental health records and reached out to his family to learn more about him and to help develop a plan to assess the level of threat he posed should officers attempt to confront him. Utilizing this multi-

disciplinary approach, officers were able to bring the scenario to a successful conclusion, without injury to anyone.

During our time with the MCU team, we were able to observe firsthand the benefits of this initiative. Officers were confronting a woman who had allegedly threatened another passenger on a bus, prompting the Tri-Met official to call police and have her removed from the bus. The MCU drove past as the subject was arguing with officers in a very animated and obviously angry manner. The MCU officer got out to assist, ascertained the subject's name, and relayed that information to the clinician. She accessed her laptop and quickly learned that the subject was receiving mental health services in the city and got on the phone with her caseworker, who gave her some background information and laid out a course of action that did not involve arresting the woman or taking her into custody on a mental health hold. Rather, the MCU clinician – armed with information from the caseworker – was able to calm the subject. The scenario resolved with an officer driving the woman to the appointment to which she had previously been on her way. We observed all of those involved in this situation – including the original responding officers – dealing with the subject in a calm, professional manner clearly aimed at de-escalation. It is important to note, however, that the MCU clinician is neither expected nor permitted to engage in situations involving armed, potentially armed, or violent subjects. In the scenario we observed, had the woman been armed or demonstrated aggression toward the officers, MCU protocols would have required the clinician to remain in the vehicle, out of harm's way.

Based on our observations and feedback we have received from the community, CIT training and the MCU car are having a positive impact on the day-to-day interactions between the police and the mentally ill. The shootings we review below, however, are not ordinary day-to-day interactions. With the exception of Mr. Perez, each of the individuals shot was in the midst of a mental health or emotional crisis, either as the result of mental illness or because of a traumatic situation that caused him to threaten or attempt suicide. Indeed, one could argue that anytime an individual confronts armed police officers and does not comply with their orders, that person is "not in his right mind," or in some sort of mental health crisis. The new training and resources described here are intended to provide the police additional options, skills, and perspectives in dealing with those in mental health or emotional crises so that officers can diffuse such situations and reduce the likelihood the encounter will result in a use of any force, let alone deadly force.

Ultimately, when making a decision about whether to pull the trigger and use deadly force, officers must weigh the level of threat the individual presents to the officer or third parties. The more information that officers have about the mental health status of a subject and other circumstances surrounding an incident, the better able they are to make this threat assessment. Our review necessarily focuses on those cases in which an officer decided to use deadly force. So while we are mindful of the mental health crises that led to these shootings, in the end our analysis of specific incidents must also focus on tactical decision-making, communications, and critical incident management in dealing with persons who are in crisis.

Recommendation 1: The Bureau should maintain its partnership with Project Respond and make the Mobile Crisis Unit a permanent team, ideally with expanded personnel, hours, and scope. The Bureau also should continue to employ the CIT program to set high standards for its officers, and should continually work to identify ways to integrate that training into patrol tactics and other standard training curricula. In addition, the Bureau should recognize this new training focus in its evaluation of shooting and force incidents and hold its officers accountable to these high standards.

SECTION ONE

Officer Involved Shootings

Summary and Analysis

March 28, 2004 ◦ James Jahar Perez

On March 28, 2004, Officer Jason Sery and his partner were on patrol in North Precinct when Sery's partner observed a stopped vehicle. As the officers drove past, the partner stated he focused on the type of car, a two year old white Mitsubishi, and compared it to neighborhood demographics, as well as the fact that the car had dark tinted windows. After the incident, the partner officer stated he alerted on the car because it did not appear to be the kind of car that belonged in the neighborhood. After entering the license plate in the computer, the date of birth with the registered owner did not appear to match up with the two occupants of the vehicle. When the officers caught up with the now moving vehicle they saw that the vehicle now had only one occupant. The officers then observed the driver of the vehicle activate his right turn signal approximately 20 to 30 feet before an entrance to a shopping center which is a shorter distance than required by law. Officer Sery's partner switched on his overhead lights to conduct a traffic stop.

The officer asked the driver, later identified as James Jahar Perez, to see his driver's license and insurance. Mr. Perez stated that he did not have a driver's license. The officer then asked if Mr. Perez had some form of identification.

According to the officer, Mr. Perez mumbled something unintelligible, and the officer stated that he again asked Mr. Perez to produce his ID.

According to the officer, Mr. Perez then turned his body toward the center of the vehicle and reached toward the interior of the car with his right hand at the same time he was rolling up the electric driver's side window with his left hand. The officer said that he ordered Mr. Perez to stop rolling up the window and opened the driver's side door to increase his visibility.

The officer then ordered Mr. Perez to place his hands on top of his head, and Mr. Perez immediately reached into the center console, which appeared to be covered by a layer of brown napkins. The officer said he then grabbed Mr. Perez' left arm and pulled it straight. He stated that he saw Mr. Perez move his right hand from the center console to his right pocket, and he instructed Mr. Perez to take his hand out or he would be tased.

While his partner was interacting with Mr. Perez, Officer Sery said that he was moving from the passenger side of the vehicle to the driver side in order to get a better view inside the car. Officer Sery said he could eventually see that Mr. Perez had his hand concealed in his pocket. Officer Sery said Mr. Perez was looking over his shoulder, focusing on the officers, while he tried to pull something from his pants pocket. Officer Sery stated that he yelled at Mr. Perez to get his hands up, but Perez ignored this order. Officer Sery said he told Mr. Perez to get his hands out of his pocket or he would shoot and repeated these orders several times.

Officer Sery said he saw Mr. Perez start to take his hand out of his pocket and the position of the hand and grip led Officer Sery to believe that Mr. Perez was retrieving a firearm in order to use it against the officers. Officer Sery fired three rounds at Mr. Perez. Sery's partner then deployed the Taser and held the trigger, which resulted in a continuous Taser cycle. One of the Taser darts embedded in the driver's seat, while the other made contact with Mr. Perez.

Cover officers responded to a request for assistance put out by the initial officers. Under direction of a sergeant who arrived on scene, the officers then approached the car. One officer felt Mr. Perez' neck for a pulse but could not find one. Medical personnel arrived, examined Mr. Perez and determined that he was deceased.

A search of the vehicle found no weapon. Two plastic baggies of rock cocaine were found in Mr. Perez' mouth. Toxicological results found a high level of cocaine in Mr. Perez' blood, indicating recent cocaine use.

A grand jury was convened and the grand jury returned a no true bill. A public inquest was also conducted with regard to the incident. At the conclusion of the public inquest, the members composed a letter expressing concern for tactics, training, and the articulated basis for the stop.

The incident was also referred to a Review Board convened to determine whether the use of deadly force and use of the Taser was consistent with Bureau training, policy, and procedure. The Board found both the shooting and the Taser use within policy. This review process pre-dated the Bureau's Use of Force Review Board, which reviewed officer-involved shootings from 2005 until it was replaced by the Police Review Board created in 2010.

Timeline of Investigation and Review

3/28/04	Date of Incident
4/22/04	Grand Jury concluded
5/3/04	Homicide Investigation completed
6/5/04	Inquest Jury concluded
7/20/04	IA Investigation completed
11/3/04	Commander's Findings completed
12/1/04	Review Board
11/2005	Mayor's and Chief's Report to the Community
1/22/10	Litigation concluded

Analysis/Issues Presented

Concerns about Bias-Based Policing

The officers articulated a thin basis – that the car did not fit with the neighborhood – for what first drew their attention to the vehicle driven by Mr. Perez. This statement caused some members of the community to believe that this incident may have been driven by racial bias. The officers' attention was heightened when they learned the car was registered to someone of a significantly different age than Mr. Perez; that, coupled with the improperly signaled turn were more objectively neutral bases for the traffic stop. The statement about the car not fitting in the neighborhood may have been the reason officers focused their attention on Mr. Perez, but was not the justification for the stop; a legal distinction but not one that completely satisfies the public perception of racial bias.

Even if the officers' focus and eventual detention of Mr. Perez on March 28, 2004, was "legal," there remained concern that the incident was an example of a trend toward bias-based policing. In response to the concerns raised by the public inquest jurors and the community, then-Chief Foxworth convened an advisory committee to hear from then-Director of Research of the Police Executive Forum, Dr. Lorie Friedell, to discuss this issue. Additionally, the Chief ordered that all officers complete "Perspectives on Profiling," a three hour class on the ethics and constitutionality of traffic stops.

Decision to Use Lethal Force

As noted above, both Officer Sery and his partner ordered Mr. Perez to take his hand out of his pocket and when he began to do so, Officer Sery fired three shots. Officer Sery asserted that the movement he saw Mr. Perez make in pulling his hand from his pocket was not Mr. Perez attempting to comply with his instruction but rather Mr. Perez about to produce a firearm. The alternative possible explanation that Mr. Perez may have been attempting to comply with the officers' instructions was not discussed in the Training Division Review. In the Commander's Findings memo, the writer completely credits Officer Sery's observations that the action was not an attempt to comply but an aggressive move by Mr. Perez to produce a weapon. The problem with such an unequivocal statement is that, in fact, Mr. Perez could not have intended to produce a weapon because he did not possess a weapon. With perfect hindsight, the most that could be said for Mr. Perez' actions was that he was trying to deceive the officers and make them think he was about to produce a weapon, a third alternative scenario

that is not considered in the Commander's memo or the Training Division Review. In contrast to the PPB internal analysis, the theory that Mr. Perez was attempting to comply with the officers' instructions and then got shot for his efforts became the cornerstone of the plaintiff's case in the civil litigation. The fact that this contention received less than adequate attention internally raises deep concerns about the robustness of the review process in this shooting.

Impact of the Slumper Training Scenario

During the investigation, both officers recalled being exposed to a training scenario referred to as the "slumper" scenario. In that training exercise, officers approach an individual who is slumped down in a car, and as the officers close distance, the individual revives, produces a firearm and shoots at the officer. The involved officers alluded to the training scenario as part of their heightened apprehension when dealing with Mr. Perez. One concern that has been raised is whether the use of such a training scenario unnecessarily raises fear in officers by presenting a scenario that, despite hundreds of vehicle stops annually, Bureau police officers have yet to encounter in the field. The case certainly can be made that it is important for police officers to recognize there is no such thing as a "routine" traffic stop. Indeed, officer safety principles may suggest the need to approach such stops more cautiously and maintain distance as opposed to what the officers actually did in this case.

We have been informed by the Bureau that a version of this scenario is still in use at the Advanced Academy Training for recruit officers. We also have been informed that instructors provide close supervision over the role players to ensure that the scenario does not automatically become a deadly force situation provided that the recruit officer uses good officer safety tactics. The scenario is currently under review to ensure that the training objectives comport with best policing practices.

Consideration of Cover and Concealment

While the Training analysis mentions that cover and concealment should always be considered when conducting a detention, neither it nor the Commander's memo suggests that Officers Sery and his partner should have taken that approach in dealing with Mr. Perez. By the time the partner officer grabbed Mr. Perez' hand after Mr. Perez failed to comply with his instructions, it may have been too late for the officer to disengage, as the Training analysis opines. Unfortunately, the PPB review documents do not scrutinize the officers' actions early in the

scenario, before the partner officer went hands on, when creating distance, seeking cover, and requesting backup as a viable alternative may have been more feasible.

In response to an earlier officer-involved shooting with similar issues (the Kendra James shooting), the Bureau conducted research on successful approaches for removing people from vehicles. As part of that study, Training Division staff traveled to other police agencies to observe other techniques.

As a result of this research, the 2004-05 Police Bureau In-Service Training included a two hour instructional block entitled "Vehicle Extractions" taught by the Bureau's defensive tactics instructors. This block of instruction included both classroom and hands-on training regarding alternative techniques in removing uncooperative subjects from vehicles.

Prolonged Activation of the Taser

As noted above, after Officer Sery fired three rounds at Mr. Perez, Sery's partner deployed his Taser on Mr. Perez, overrode the five second cycle, and kept the Taser activated for a period of three minutes and 19 seconds. We have reviewed scores of Taser activations and this prolonged application is by far the longest in duration that we have ever seen. While only one dart struck Mr. Perez, the Training analysis indicated that even a close miss by the second dart potentially would have allowed the cycle to be complete, making the Taser effective. The partner officer indicated he wanted to keep the Taser activated on Mr. Perez until backup units arrived. The Training Division Review concludes that this "uncommon" deployment of the Taser was appropriate considering the belief that Mr. Perez was armed, the lack of appropriate cover, and the lack of additional officers on scene. While the Commander's memo suggests that a continual on-off cycling of the Taser would have been more effective, it does not critique the length of time the Taser was used in this case. This is true even though Chief Foxworth's Report to the Community on the Perez shooting mentions a 2003 training bulletin addressing the issue of multiple prolonged discharges.

In its 2009 report, PARC recommended that when a Taser is used it should be for one standard [five second] cycle. More recently, research conducted by the United States Department of Justice, National Institute of Justice on the potential dangers of Taser use focused on the heightened risk when persons are subjected to multiple or prolonged deployments. In light of concern about prolonged Taser

use both prior to and after the Perez shooting, the Bureau's internal review processes should have given this issue greater attention.

While current PPB policy suggests that when subsequent deployments of the Taser are unsuccessful, the officer should reevaluate his or her use of the Taser, it does not regulate prolonged Taser use.

Recommendation 2: PPB should reexamine its current policy on Taser use in light of current research indicating the elevated dangers of prolonged Taser use.

Post-Shooting Tactical Engagement of Involved Officer

After the shooting, Officer Sery was appropriately removed from any tactical post-shooting activities. However, the responding sergeant did not disengage the partner officer from post-shooting responsibilities. As a result, this officer was part of the approach team, handcuffed Mr. Perez to the window post of the car, and felt Mr. Perez' neck for signs of a pulse. As the PPB training review expressly notes, it is preferable that officers involved in the shooting not be deployed for post-incident tactical activities. It is unclear however, whether and how PPB addressed this identified issue with the responding sergeant.

As a result of a recommendation stemming from the Training Division, the Critical Incident Management class mandated for all sergeants and other command staff teaches that supervisors should relieve involved and witness members in an officer-involved shooting as soon as "tactically feasible."

Officer and Citizen Safety Issues Raised by Post-Shooting Response

The Commander's memo expressly noted that one responding officer stated that he was travelling to the post-shooting scene at speeds approaching 80-85 mph and 55-60 mph through residential areas. The Commander indicates that the high speed driving response appears to have continued even after information had been provided that the officers were uninjured and the incident was under control. The Training Division Review recommended that officers be reminded about the tragic incident in which a PPB officer was killed as a result of responding "hot" to a call. It is unclear whether and how this identified concern was communicated back to involved officers or the Bureau as a whole.

Development and Implementation of an Action Plan

As noted above, the Commander's Findings and Training Division Review make suggestions on ways to learn from and improve performance from a review of the Perez shooting, but it is unclear whether and how these recommendations were communicated to the involved officers and the Bureau as a whole. Further, other than a finding that the deadly force was in policy, any issues considered by the Review Board do not exist in writing. Since the Perez shooting, a more robust feedback loop has been designed whereby the Review Board Coordinator is responsible for ensuring implementation of the recommendations made by the Review Board. More recently, the degree of transparency provided about Review Board deliberations has increased significantly through public reporting of the outcomes and recommendations of the Board.

The Testimony of an Expert in the Grand Jury

According to sources, an expert was called to the grand jury to testify about how officers' perceptions and memory can be negatively impacted during high stress encounters and how long it takes officers to react effectively to a threat. This expert has been called by attorneys defending police officers in civil litigation to buttress contentions that the officer-involved shooting was reasonable. While there may be a role for this type of expert in civil litigation where the adversary system provides for cross examination of expert witnesses and an opportunity to produce a competing expert witness, such a move is questionable in a grand jury setting, where those opportunities do not naturally exist. The objectivity of the grand jury was called into question by some community members as a result of the District Attorney's decision to call this expert.[1] Our understanding is that neither this expert, nor any similar expert, has returned for more recent grand jury appearances.

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[1] We recognize that the decision to call the expert rested with the District Attorney's Office, but for the sake of a complete review, we felt we would be remiss not to address this issue.

[2] This shooting incident provided impetus for the Bureau to contract with a police expert who provided numerous recommendations to the Bureau on ways to improve SERT practices and protocols. In addition, the Review Board recommended external auditing of SERT practices on a regular basis.

[3] The Southeast sergeant said in her Internal Affairs interview that she attempted to get on the radio to discuss the situation with her fellow sergeant, but that she got "stepped

Quality of Investigation and Review

Delay of External Review

This report – eight years after the incident – is the first time this shooting has been the subject of external review. A large reason for this delay was the City's initial position that incidents subject to civil litigation would not be reviewed until that litigation had concluded, which did not occur in this case until 2010. As a result, this case escaped all of the PARC reviews. Fortunately, protocols have changed and been reinterpreted so that the existence of civil litigation will no longer hold up the external review process for officer-involved shootings. Even so, the tardy outside review of this case can still identify issues worthy of consideration that may not yet have been sufficiently addressed by the Bureau. In addition, the review of a 2004 incident can be used as a gauge to compare policies, protocols, and systems in place at the time to the reforms that have been made over the past eight years.

Investigators' Access to Grand Jury and Public Inquest Transcripts

The investigative report indicates that Bureau investigators were expressly instructed not to access and review the grand jury transcripts in this matter. Assuming such transcripts were available, it is difficult to fathom why internal investigators would be prohibited access. Clearly, a fuller picture of the incident would have emerged from review of the transcripts of grand jury proceedings, during which officers and witnesses testified under oath about their observations of the incident. Since this incident, Bureau investigators now routinely access grand jury transcripts and review them prior to conducting follow-up interviews. This routine access of grand jury transcripts is just one example of how the Bureau has progressed toward complete and thorough investigations of officer-involved shootings.

Effective Use of Crime Scene Diagrams

The Bureau prepared professional quality scene diagrams and put them to effective use when interviewing witnesses. This observation indicates an understanding that even in 2004, the Bureau recognized the importance of the preparation and use of visual materials to assist the fact finder in gauging the observations of witnesses to the incident.

Effective Witness Canvass

Because this incident occurred on a weekend afternoon in a shopping center parking lot, there was a multitude of witnesses who were in a position to see or hear the incident. As a result, it was a daunting task to canvass and identify potential witnesses to the event. Responding officers and investigators showed attention and devotion to this task by giving decision makers access to the statements and perspectives of a number of civilians who were at the shopping center that day.

Diligent Location of Witnesses Who Left the Location

In reviewing investigations completed by other law enforcement agencies, we have been struck by the phenomenon of seeing a fairly comprehensive initial canvass for witnesses, but insufficient or no follow up with regard to witnesses who may have left the location by the time investigators were prepared to conduct interviews. In this incident, the report shows numerous and repeated efforts to identify and follow up with interviews of witnesses who may not have made themselves available the night of the incident. Such an approach in this case is testament to the Bureau following good investigative practices with regard to the identification and interviewing of civilian witnesses.

Analysis of Radio Traffic

In our experience, the collection and assessment of radio traffic is an essential component of a critical incident investigation. Radio traffic provides insight on the contemporaneous thought processes and response of involved officers and supervisors. It has also been our experience, however, that some law enforcement agencies insufficiently focus on the retention and the analysis of radio traffic. In this shooting, investigators collected the relevant radio traffic and created an effective timeline of events based on that radio traffic. The timeline provided reliable markers of the chronology of events in this incident.

Designation of Subject Officers

In the IA investigation, only Officer Sery is listed as a subject of the investigation even though his partner was tactically engaged in the incident and used control holds, pushes, and the Taser on Mr. Perez. His tactical decision-making was integral to how the incident proceeded. In our view, internal review is better served if all officers who are integrally involved in the tactical response that leads

to a shooting are identified as subjects, even if they did not personally use deadly force. In our experience, it is sometimes the non-shooter officer who makes subpar tactical decisions that then force another officer to use deadly force and, in those cases, the accountability of the non-shooter should be questioned.

We have discussed this issue with members of the Bureau's command staff, who agree with this principle and have indicated that it is consistent with current practice. Following our discussions, IA revised its written Standard Operating Procedure specifically to require that all Bureau members "integrally involved in the tactical response leading to the use of deadly force will be considered subject members for the purposes of determining whether their actions were within policy."

Recommendation 3: PPB should ensure adherence to its newly-adopted written protocols requiring that all officers who are tactically involved in events leading up to the shooting be identified as potential subjects.

Contemporaneous Interviews of Subject Officers

While the non-shooting partner officer was interviewed the night of the incident, it was not until the next day that Officer Sery was interviewed. No explanation was provided in the file regarding the scheduling of Officer Sery's interview.

We are aware that for years the Bureau's Homicide detectives have asked all officers involved in an officer-involved shooting for a voluntary interview on the day of the incident. Over the past twenty years, there has apparently never been an occasion in which an involved officer has provided a voluntary interview that quickly. In cases in which the involved officer has agreed to a voluntary detective interview, the timing of that interview is controlled by the involved officer and his or her attorney. While Bureau detectives would readily interview involved officers on the date of the shooting if the involved officer and his or her attorney would agree to do so, unfortunately in recent memory no involved officer or counsel for the officer has so agreed.

This circumstance is unfortunate. Public confidence in internal police investigations would be enhanced if involved officers would agree to be interviewed on the date of the incident. While it is laudable that there has, until recently, been a tradition of involved-officers agreeing to be voluntarily interviewed, the fact that part of the bargain has required a delay of at least a day (and often longer) to gain that interview undercuts the utility of having a

voluntary interview at all. Because the determination of whether and when to agree to a voluntary interview lies solely within the discretion of the Bureau officer and counsel, we urge that Bureau members and their legal representatives reconsider their approach to this issue to increase public confidence in the Bureau's investigative process.

East County Major Crimes Task Force

PPB has traditionally relied on non-PPB members of the East County Major Crimes Task Force to assist in interviewing sworn and civilian witnesses. In our review, we found some interviewers to appear to be reading from a script and asking irrelevant questions of responding officers who were not involved in and did not witness the shooting. We also found that some interviewers asked some civilian eyewitnesses leading questions.

In 2006, PARC recommended that PPB should study whether the benefits of using East County Major Crimes Team investigators on deadly force cases outweigh the liabilities of using them and suggested training for non-PPB personnel. Because the Perez shooting predated the PARC recommendation, our review serves to indicate that the use of the team did present an issue in this case as well.

The Role of IPR

At the time of the investigation and review of the Perez shooting, IPR played a minimal role in the review of the internal investigations and the review process. Pursuant to protocols in place at the time, the only involvement IPR had then was to receive a summary of the investigative report when it was completed. Since that time, IPR has assumed a significantly greater role in both the investigative and review process. We expect that the investigation into and review of the Perez shooting would have been more robust had IPR in 2004 held its current role with respect to officer-involved shootings.

November 4, 2005 ◦ Raymond Gwerder

On November 4, 2005 at 2:14 p.m., the Bureau of Emergency Communications (BOEC) dispatched officers from the East Precinct to an apartment on NE 118th Avenue, telling them that Raymond Gwerder was reported as suicidal, threatening to kill himself and in possession of a Glock handgun. Officers were also informed that Mr. Gwerder was not happy that the police had been notified. The handgun information was confirmed shortly by a perimeter officer at the scene. Seven officers and a sergeant took perimeter positions around the property, which was the center unit of a triplex apartment building. Another sergeant assembled an arrest team north of the apartment. One of the perimeter officers was CIT trained and was instructed to call the subject. When he got through, Mr. Gwerder insisted that he did not want to kill himself but became agitated when the officer explained that the police needed to speak to him face-to-face. Mr. Gwerder said that if the police stormed his apartment, he would kill a couple of them and did not care. This information was broadcast to the other officers at the scene. The incident commander also received similar information from Mr. Gwerder's sister in Seattle who had just spoken to her brother on the telephone.

During this period, another perimeter officer saw Mr. Gwerder walk out the back of his apartment into his patio area holding a handgun and smoking a cigarette while on a cell phone. This officer saw the subject point the gun down sometimes and across his body or at his head at other times. He also saw the subject pointing the gun at the back patio door as if expecting someone to come through it. He broadcast this information to the other officers.

About 30 minutes after the precinct officers arrived at the scene, the perimeter sergeant requested that BOEC activate the Special Emergency Reaction Team (SERT) and Hostage Negotiation Team (HNT) (recently renamed the Crisis Negotiation Team – CNT). SERT/HNT arrived less than an hour later. SERT officers were instructed to go to the perimeter locations and start replacing the precinct officers. Before this maneuver was complete, officers heard a shot fired and determined that this was probably from the subject. No officers were hurt, nor was the subject. The incident commander learned that one of the other two triplex units contained a woman and two children. He had made preparations to evacuate them, but decided to delay that operation. The incident commander directed the HNT team to make telephone contact with Mr. Gwerder. The HNT negotiator began conversing with Mr. Gwerder, assuring him that no one would try to storm the house or hurt him. He said that he was inside the house and had

accidentally fired the shot. Mr. Gwerder reiterated that "if they come in, I'm gonna shoot," and said he was with a friend whom he named but would not describe further. Little of this information was broadcast to any of the other officers.

Eight and a half minutes into the conversation, Mr. Gwerder was killed by a single shot from the AR-15 long rifle of Officer Leo Besner, one of the SERT officers located in an adjacent property overlooking the backyard and patio area. This officer had observed Mr. Gwerder wander around the back of the property holding a handgun and appearing to talk on a cell phone. At one point, the shooter officer heard the sound of a handgun slide and then saw Mr. Gwerder hold the gun up level with his eye and appear to point it in a sweeping motion at possible targets in the back yard. This information was conveyed to the other SERT officers. Mr. Gwerder then turned and walked back toward the patio door to the apartment. At that moment, Officer Besner shot him once through the lower back. The shot went through the kitchen window of the residence where the shooter and his partner had taken their position and felled Mr. Gwerder, 120 feet away. After the arrest team sergeant determined that Mr. Gwerder did not appear to be moving or breathing and the handgun was on the ground but no longer in his hand, officers moved in to secure him. An officer fired a Taser at him and, seeing no response, the arrest team handcuffed him. Paramedics arrived approximately twenty minutes after the shot and pronounced Mr. Gwerder dead.

From his perimeter location in an adjacent residence, the shooter officer could not always see Mr. Gwerder's entire body as he moved about the backyard. His view was partly obscured by a five-to-six foot fence and a shed in the backyard. He explained that he had considered taking a shot when he saw Mr. Gwerder point his gun and sweep it from east to west as if searching for something but he explained that he could only see the top of his head at that time. Shortly after, when Mr. Gwerder walked back up his patio toward the back door, Officer Besner could see all of his body. The shooter officer did not know if other SERT officers were yet in position or exactly where. He did not know if there was believed to be anyone else in the apartment. He did not know whether HNT was in contact with the subject or whether they had received any information from them. Officer Besner did not broadcast his intention to shoot or request input or authorization.

SERT officers are permitted to make independent decisions to use deadly force if they "reasonably believe" that a suspect poses "an immediate threat of death or serious physical injury…to themselves or others." They may also use deadly

force "to effect the capture or prevent the escape of a suspect where the member has probable cause to believe the suspect poses a significant threat of death or serious physical injury to the member or others."

The shooter officer based his decision to shoot on many reasons, among them: (1) the subject's actions with the gun in the backyard and his threat to shoot police who entered his house appeared potentially homicidal not just suicidal; (2) some of his SERT perimeter colleagues had said they had concealment but not adequate cover; (3) the SERT assault/arrest team was not fully in place yet; (4) the northern triplex unit had not yet been evacuated; and (5) the subject could go out the front door and pose a threat to the uniformed officers he had recently seen clustered outside the front of the residence. He also based his decision on the fact that he did not have certain information, namely whether precinct officers were still in their original positions or had been replaced by SERT officers; whether SERT officers were moving along the perimeter; whether the subject, if he returned inside, could get access to the other triplex unit or shoot through the walls into it; what the subject was aiming at or whether he was trying to acquire a target; or whether there was someone else in the apartment. Based on what he had observed and on the many unknowns, the officer stated that he felt that he should neutralize the subject while the opportunity existed.

Timeline of Investigation and Review

11/4/05	Date of Incident
11/17/05	Grand Jury proceedings
Late 2005	First Training analysis (focused on the tactics and decision-making of the East Precinct officers and supervisors)
8/25/06	IA investigation completed
Late 2006	Second Training analysis (focused on the tactics and decision-making of the SERT and HNT officers and supervisors)
3/19/07	Commander's Findings completed
4/25/07 and 5/4/07	Use of Force Review Board

Analysis/Issues Presented

Decision to Use Lethal Force

Based on the location of the shot – in the subject's back while he was walking up the patio toward his back door – the decision to shoot appears to be essentially precautionary in nature. This can be a permissible justification for use of deadly force under PPB policy and established United States Supreme Court case law (*Tennessee v. Garner* (1985)), but the Bureau currently requires a slightly higher threshold – probable cause to believe the suspect poses a significant and immediate threat to others if he is allowed to continue. It is unclear whether either the Bureau or the Use of Force Review Board specifically scrutinized the actions of the shooter officer under this standard or even under the previous, somewhat more permissive "imminent threat" standard. More importantly, given the fact the grand jury had found the shooting to be legal, we found no documentation to suggest that the Bureau attempted to debrief or give guidance to its members in light of this example of a possibly borderline use of the precautionary deadly force principle.

The Training Analyses enumerate all of the logical factors for shooting that Officer Besner expressed in his interviews. None of these factors, however, provide strong support for the urgent need to shoot. The officer stated what he observed and knew about the subject that made him apprehensive but he also said, "there were too many unknowns," as an element justifying his decision. This raises the possibility that he decided to shoot, in part, as a means of solving his "too-many-unknowns" problem. By omitting any real critique of the shooter's tactical decision-making, the Training Analyses can appear to condone this logic: "Regardless of the way that he got there, [the shooter's] decision to use Deadly Force was articulated in a manner that made sense."

It is important to note, however, that the Gwerder shooting instigated a significant dialogue within the Use of Force Review Board about the Bureau's use of deadly force policy itself as well as officers' understanding of the policy. The Review Board recommended that the Bureau further revise the wording of the policy to clarify how officers should define the level of threat needed to justify using deadly force to prevent the escape of a suspect. At the time of the Review Board (2007), the policy had recently been rewritten and, among other changes, the somewhat murky and interchangeable use of the terms "imminent threat" and "immediate threat" were superseded by the consistent use of "immediate threat." The Bureau enlisted the assistance of specialists from the City Attorney's Office

to help train staff on the new policy and used a previously made DVD presentation of the issues at roll out training as well, another recommendation from the Review Board. Interest remains in the Bureau and the City Attorney's Office in further refining the policy and making sure the training eliminates ambiguity about the policy. We hope to explore these ongoing developments in our remaining reports.

Activation of SERT/HNT

The incident commander called SERT/HNT 30 minutes into the incident. This appears to be an extended time under the circumstances. An armed, barricaded suspect is a mandatory SERT call out. [*See* Directive 721.000 and unit SOPs.] The first Training Division Review deemed this a timely notification because it was done within minutes of a patrol officer at the scene making phone contact with the subject who then threatened to shoot any officer who entered his apartment, but the minimum threshold – armed, barricaded suspect – had been established much earlier.

Multiple Training Analyses

The first Training Division Review made two excellent recommendations regarding SERT/HNT: (1) More joint training between SERT and HNT personnel, especially employing scenarios emphasizing communications, and (2) Mandatory participation of precinct commanders in SERT/HNT scenario training. The second Training Division Review suggests that these recommendations have been addressed "by the recent SERT audit and the new Critical Incident Command Program."[2]

The Training Division stated in the first analysis – which focused solely on the actions and decision-making of the precinct officers and supervisors – that it would not address issues related to SERT and HNT because it did not have "subject matter expertise" to do so. Many months later, Training issued a second analysis focused on SERT and HNT. The Commander of the Bureau's Tactical Ops Division was assigned to conduct the review in preparation for the Force Review Board and opined that Training Division had personnel with "enough tactical expertise to thoughtfully review and comment on this matter." His

[2] This shooting incident provided impetus for the Bureau to contract with a police expert who provided numerous recommendations to the Bureau on ways to improve SERT practices and protocols. In addition, the Review Board recommended external auditing of SERT practices on a regular basis.

opinion persuaded executives but the second, and more substantive, Training analysis was thus delayed by almost a year, causing a substantial delay in the final internal evaluation and decision-making about the incident. This delay aside, we commend the decision to conduct a second Training analysis. SERT tactics and decisions should not be immune from the rigorous examination of the Bureau's shooting review simply because of their special operations and expertise.

Recommendation 4: The Bureau should establish a policy that Training Division will be expected to evaluate the tactics and decision-making of every unit in the Bureau, including SERT and CNT (previously referred to as HNT), so as to avoid the ambiguities and delay following critical incidents. A written policy would enshrine what we are told is now current practice.

Communications Issues

Within the likely spectrum of issues related to an armed, barricaded, suicidal subject, the main tactical flaws in the operation were self-inflicted by PPB and related to poor communications between and among precinct personnel, SERT, and HNT. First, the precinct officers still in place or moving back to the command post did not receive any intelligence from the SERT officers who had taken up perimeter positions, nor did they relay their new positions because SERT and precinct personnel tend to broadcast on different frequencies. This lack of information about officer position became important because Officer Besner had to speculate about whether officers he could not see might be in harm's way. Second, the HNT team did not know where the subject was (outside as opposed to inside) or what he was doing (pointing a gun and appearing to seek a target) because they received no intelligence from the liaison officer. Third, the SERT team did not receive any information about the progress of negotiations or what the subject had told the negotiator or even that HNT was actively engaged in negotiations because the liaison officer did not know much of this information and relayed even less.

PPB critical incident doctrine holds that where SERT and HNT are present and active at an incident, the incident commander, the SERT lieutenant, and the SERT/HNT liaison officer should stay physically close to one another throughout the incident to facilitate information exchange and make sure all three teams are aware of relevant information at the same time. The incident commander reportedly "wandered away" on occasion, taking phone calls. Additionally, the SERT/HNT liaison was not monitoring the negotiations because he was not

sufficiently conversant with the wireless infrared system in use for this purpose. These systems failures point to performance shortcomings by the incident commander and the liaison and perhaps even the SERT lieutenant who could have recognized what was happening, or not happening, and tried to correct it. The very short time span, however, from the initiation of negotiations to the firing of the fatal shot – eight and a half minutes –allows only speculation about whether the three officers would have corrected their operational relationship quickly thereafter. Neither the Training analyses nor the Detective and IA investigations provide any persuasive evidence that, had these problems been cured, the outcome would have been any different. If we take the shooter officer's statements about his rationale at face value, it seems likely that receiving accurate, timely information about the progress of negotiations would not have deterred him from firing. That being said, it is always important to tease out these operational issues and address them, because in future scenarios, such operational deficiencies might, in fact, make a crucial difference in outcomes.

The Bureau now provides a periodic forum for this type of analysis outside the confines of the shooting investigation process. The Assistant Chief of Operations meets quarterly with SERT and CNT supervisors and experienced Critical Incident Commanders (CICs). The CIC position was created by a recent policy change (Directive 720.00) aimed at creating consistency in the way the Bureau handles critical incidents. One of a small group of specially trained CICs is required to respond to and assume command of any critical incident involving SERT and CNT. The CIC reports directly to the Assistant Chief of Operations during the incident.

Analysis and Review of Tactical Questions

- Was the SERT/HNT liaison who was unfamiliar with the infrared audio monitoring equipment inept, inattentive, or inadequately trained? The Bureau's reviews do not address this question.

- Was the fact that perimeter SERT officers had obscured views of the subject in the backyard patio area unavoidable or did it reflect a poor choice of perimeter location? Training and IA do not address the question.

- During our review, HNT members reported to us that an HNT training for BOEC was scheduled and that BOEC is undergoing a major realignment

of policy regarding dealing with the mentally ill. We will explore the effectiveness of this program in future reports.

Ineffective Crime Scene Diagrams

The investigation file contained only one diagram of the scene. It was not to scale and poorly labeled. As the Bureau has done in other cases, crime scene investigators should consistently create diagrams with sufficient detail so that they can serve as tools to help evaluate distances, lines of sight, options for cover, and other operational challenges in cases of this nature. Using diagrams during witness interviews can also illuminate the incident for investigators and reviewers.

Delay in Internal Review Process

The IA investigation took eight months following the grand jury proceeding. The total internal review process, including the Use of Force Review Board, took eighteen months from the date of the incident. As we have stated in our comments about other cases in this report, while PPB's investigative and evaluative processes for critical incidents are commendably extensive, this attention to detail does not justify the long delays before the Bureau makes final determinations about tactics, training and accountability.

July 19, 2006 ◦ Jerry Goins

On July 19, 2006, East Precinct received a call that Jerry Goins, the suicidal ex-boyfriend of a female employee of the Naval Recruiting Center, had told the female he was coming to her place of employment. Acting Sergeant (A/S) Richard Steinbronn responded with a Cadet to the call. While Steinbronn and the Cadet were responding, Mr. Goins informed the female that he was not coming to the office, and a call was updated and broadcast to reflect that fact. A/S Steinbronn and the Cadet responded to the office and Steinbronn talked to the female. Steinbronn also talked briefly on the female's cell phone with Mr. Goins who eventually hung up on him. A/S Steinbronn suggested that the female leave her place of employment and not stay at her residence for a few days. A/S Steinbronn then cleared the call and he and the Cadet returned to the police vehicle parked in front of the Naval Recruiting Center. While at the vehicle, A/S Steinbronn was updating information in the patrol car's Mobile Digital Computer when the Cadet observed a man holding a firearm at his side and walking towards the Center. The Cadet alerted Steinbronn to his observation, and Steinbronn immediately ordered Mr. Goins to drop the weapon while both Steinbronn and the Cadet exited the police vehicle. Goins pointed his weapon in the direction of the Cadet, and then at A/S Steinbronn, at which time Steinbronn fired several rounds at Goins. As he was struck by gunfire, Mr. Goins raised his gun to his own head, fired one round, and dropped to the ground. The Medical Examiner found the cause of death to be suicide.

Timeline of Investigation and Review

7/19/06	Date of Incident
1/15/07	Homicide Investigation completed
5/10/07	IA Investigation completed
6/12/07	Commander's Findings completed
8/14/07	Use of Force Review Board

Analysis/Issues Presented

The Initial Dispatch to the Wrong Location

The investigative reports and review indicate that because the initial information was sketchy, the first dispatch to the call was to the wrong location. However, beyond this mention, the investigation and review engaged in no further analysis about whether this incorrect dispatch should be handled as a training or briefing issue. In our view, a robust review of a shooting should consider, assess, and devise an action plan to address seemingly collateral issues such as this one.

Acting Sergeant's Decision to Take a Cadet to a "Hot Call"

As noted above, A/S Steinbronn decided to take an unarmed Cadet ride-along to a suicidal person call. While the call was downgraded after the Bureau received further information from the female caller, the fact remains that the original decision by the Acting Sergeant was to have a Cadet accompany him to a "hot call." As it turns out, the presence of the Cadet was of great assistance to A/S Steinbronn, as the Cadet was the first to alert to the presence of an armed Mr. Goins. Moreover, A/S Steinbronn wisely instructed the Cadet to seek cover and then to seek even better cover as it became clear that Mr. Goins presented a deadly threat. However, these facts do not eliminate the question of whether it was advisable to take an unsworn, unarmed, ride-along to what was initially considered to be a "hot call." This issue was not addressed in the analysis and review of the incident.

This case stands in contrast to the shooting of Jason Spoor, discussed below, where one officer who had a Cadet ride-along wisely instructed the Cadet to remain at a staging area rather than accompany officers on a potentially dangerous approach.

Recommendation 5: The Bureau should consider whether its protocols on the use of Cadets and their roles during ride-alongs need to be reassessed.

Decision to Clear the Call

According to investigative reports, A/S Steinbronn advised the female caller that she should leave her place of employment and not stay at her residence for a few days until Mr. Goins returned to his assignment of duty in California. Apparently, the female was agreeable to this suggestion and was preparing to leave when A/S

Steinbronn cleared the call and returned to his police vehicle. Neither the investigation nor review addressed the question of whether it would have been advisable for A/S Steinbronn to wait the extra minutes and accompany the female to her car.

Post-Shooting Response and Delay

When Mr. Goins fell he still had his gun in his hand, so A/S Steinbronn made the decision to activate SERT to take Mr. Goins into custody. A team responded and fired five rounds of various types of non-lethal munitions at Mr. Goins before approaching. Largely as a result of the time it took SERT to respond, 47 minutes passed from the time of the shooting until a SERT medic first checked Mr. Goins' vital signs. The decision to activate SERT and the resulting response time was discussed during the review of the incident and was found to be consistent with PPB policy.

PARC has repeatedly reported concerns about the delay between an officer-involved shooting and the rendering of medical aid and suggested modifications to policy to emphasize a need to respond more quickly in critical incidents. One alternative approach to relying on and needing to wait for a deployment by the SERT team is to outfit officers with ballistic shields so that officers can approach more quickly. More recently, in response to the shooting of Aaron Campbell, the Bureau has equipped sergeants' cars with ballistic shields. That approach was not discussed as an option in the Goins shooting review and analysis.

Lengthy Delay before Notifying Medical Examiner

It took approximately three and one-half hours before PPB notified the medical examiner that they had a dead body to retrieve. While it was clear that Mr. Goins had expired, and there is some value in being able to photograph the crime scene with the decedent still present, the time delay in notification in this case seems extreme. We have reviewed cases in which a lengthy delay in retrieving a dead body has raised concerns about insensitivity by responding investigative personnel. This issue was not identified during the review of this incident.

Quality of Investigation and Review

Lengthy Delay before Interview of the Shooter Officer

In this case, A/S Steinbronn was not interviewed until one week after the incident. Because the shooting officer had not yet been interviewed, the Coroner's office delayed its determination on cause of death. The only explanation for the delay provided in the case materials seemed to stem from the unavailability of A/S Steinbronn's attorney.

As noted above in our discussion of the Perez shooting, we believe that in order to maintain community confidence in internal investigations, involved PPB personnel should be interviewed on the date of the incident. The week long delay in this case seems inordinately long and meant that the officer's recollection was not captured close in time to the event. It is evident from the investigative file that the time in which the voluntary interview was obtained in this case was controlled by the officer and his attorney.

More recently, we understand that PPB officers involved in fatal shootings are sometimes not providing a voluntary statement to detectives at all. In those situations, on the date of the shooting IA serves notice on the officers that they will be compelled to submit to an IA interview 48 hours after the incident. The reason for the 48-hour delay is the current labor agreements between the City and the Bureau officers' bargaining units. As noted in further detail below, we believe that 48 hours is too long to wait for a statement from involved personnel and advocate for a restructuring of the labor agreements mandating the 48-hour delay.

Cadet Interviewed in the Presence of the Cadet Advisor

While the Cadet was interviewed the date of the incident, his Cadet Advisor was present with him. It is unclear whether the Cadet requested the presence of his Advisor during the interview or whether the Advisor took it upon himself to be present. Absent some particular need, witnesses normally should be interviewed without other persons present. In this case, no articulated need was presented in the investigative reports.

Recommendation 6: The Bureau should consider developing protocols for how Cadets are to be interviewed in future critical incidents.

Thorough Canvass for Witnesses

As we have seen in our review of other Bureau officer-involved shootings, the witness canvass and interviews in this case were thorough. Because this incident occurred in late summer afternoon in a busy shopping mall, there were numerous potential witnesses who observed Mr. Goins as he made his way towards the Naval Recruiting Center. Investigative personnel identified these potential witnesses and obtained a complete account of their observations.

Lack of Independent Follow Up in the IA Investigation

While the case was referred to a Bureau IA investigator there apparently was no active follow up in this case. For example, no one asked A/S Steinbronn additional questions about tactical decision-making involving issues expressly noted here, such as his decision to clear the call before the female had left the premises. Additionally, none of the SERT members was interviewed during either the criminal or IA investigation about their response and use of less lethal munitions.

In its 2006 Report, PARC recommended that PPB policy should require that Internal Affairs, as part of its investigation of deadly force incidents, interview the involved officers, unless Homicide's investigation has covered all appropriate issues relating to policy, training, and tactics. In 2009, PARC made an additional recommendation that IA re-interview key civilian and officer witnesses to officer-involved shootings unless Homicide has covered all relevant policy, training, and tactical issues. Because the 2006 and 2009 recommendations post-dated the investigation of the Goins shooting, our observations only serve to add additional weight to the acumen of the PARC recommendations on this issue.

In the more recent officer-involved shootings we reviewed, we note that IA interviews of involved and witness officers explore all issues relating to policy, tactics, and training. Following our discussions with Bureau command staff in preparation of this report, IA revised its written Standard Operating Procedure specifically to require this expanded scope of review.

Training Division Review Does Not Cite Its Author

The Training Division Review that appears in the investigative files does not note the name of its author. The lack of authorship could contribute to a lack of

ownership of the document. Additionally, it becomes more difficult for external reviewers to learn the author of the Training analysis.

In the more recent Training analyses we reviewed, the authors have been identified. The Bureau has informed us that protocol over the past several years has been for the authors of the Training Division Reviews to be identified on the document.

Training Division Review Refers to Information Not in the Investigative File

The Training Division Review states that A/S Steinbronn had spoken to Mr. Goins on the phone prior to the incident and as a result of that conversation felt that Mr. Goins was so incoherent that he did not think Mr. Goins could formulate a plan. This observation of A/S Steinbronn does not appear in A/S Steinbronn's interview and its origin is unclear. In our view, the information used to draw conclusions about the tactical decision-making in officer-involved shootings should be limited to information collected during the investigation and included in the file. If PPB protocols do not already dictate this requirement, we recommend that protocols be developed that do so.

August 20, 2007 ◦ Lesley Stewart

On August 20, 2007, East Precinct officers were dispatched to an apartment on SE Stark Street, when a female caller said that she, her 22-year old son, and her boyfriend, Lesley Stewart, were all fighting in the apartment. The caller also reported that Mr. Stewart had a gun. Officers arrived and established visual surveillance of the apartment at 6:36 a.m. Ten minutes later, two two-person teams with AR-15 rifles positioned themselves with cover to observe the front and the back of the apartment. Other officers took positions establishing a perimeter over the next 30 minutes. As the officers were setting up, they did not hear any sounds of fighting or gunshots. Based on the initial dispatch information and from updates, they had the following information:

- The initial call to 911 had included sounds of a domestic disturbance and possible gunshots.
- The caller said Mr. Stewart had a gun and had threatened to kill her.
- Mr. Stewart might be preventing the woman and her son from leaving the apartment.
- Mr. Stewart had threatened to "do something" if the police did not leave the location.
- Mr. Stewart was a known "Crip" gang member on parole for attempted murder.

When the perimeter had been established, the incident commander, an acting lieutenant, tried to make contact with Mr. Stewart by telephoning him several times and by hailing him over a loud speaker when he hung up. These short, interrupted conversations went on repeatedly over a span of approximately 30 minutes. During that time, the officers did not hear from the other two occupants of the apartment, but they could see Mr. Stewart moving around inside the apartment. Mr. Stewart also removed an air conditioner from a rear window of the second story apartment and looked out of the hole, perhaps in search of an escape route, or to identify the position taken by the rear AR-15 team inside a ground floor wooden structure. None of the officers observed Mr. Stewart with a gun.

The incident commander activated SERT approximately one hour after the precinct officers arrived at the scene. (SERT did not arrive until after the incident

was resolved.) Fifteen minutes later, the caller and her 22-year old son walked out of the front door of the apartment. They were debriefed immediately and confirmed that no one besides Mr. Stewart was left in the house. This information was broadcast to the perimeter officers but may not have been heard by the rifle team in the rear.

When the AR-15 team in the rear saw Mr. Stewart in the back bedroom again, they commanded him to exit the house out the front door. He appeared to look toward them then go to a bedroom closet and reach up into it. Officer Stephanie Rabey fired one round from her AR-15 through the open window of the ground floor wooden structure, striking the window frame of the back bedroom of the house and injuring Mr. Stewart slightly in the head with shattered bullet fragments. Mr. Stewart made some threats to "take officers with him" but surrendered very soon afterward and exited the house.

Officer Rabey's stated reason for using deadly force at this time was that she believed Mr. Stewart was reaching for a weapon and preparing to turn and fire toward her. She was also concerned that she, her partner and other officers in other positions behind them had insufficient cover to be safe from Mr. Stewart's potential rounds. It is not entirely clear whether the shooter officer or her partner knew that the other occupants of the apartment had safely exited out the front door shortly before the shooting, because the officers in the rear were giving commands to Mr. Stewart at about the same time that this information was broadcast to the perimeter.

A search of the premises discovered a loaded handgun in the car associated with Mr. Stewart and his girlfriend. A grand jury later indicted Mr. Stewart on a Felon in Possession of a Firearm charge.

Timeline of Investigation and Review

8/20/07	Date of Incident
8/23/07	Grand Jury proceedings concluded
11/1/07	Detectives' Investigation completed
4/2/08	IA Investigation completed
7/23/08	Training Division Review completed
10/17/08	Commander's Findings completed
12/3/08	Use of Force Review Board

Analysis/Issues Presented

Tactical Positioning

Officer Rabey's and her partner's position was one story below and at an oblique angle to the bedroom window, partially obstructing a full view through the rear window. The location was also close enough (15-20 yards) to the subject apartment window that the officers cited this short distance as a major factor in their sense of vulnerability. The rifle team was apparently responsible for choosing the position they took. The Training Division Review and the Commander's Findings conclude that they made the best available choice, but do not back this up with a persuasive, detailed description of the immediate surroundings. To Officer Rabey, the location provided neither concealment nor a safe barrier. She cites her perception of her and her partner officer's vulnerability as a factor in her decision to shoot. In light of this fundamental controversy, the Training analysis would have been more persuasive in labeling the shooter's location as the "best available choice," if it had acknowledged and addressed alternative possible scenarios.

Perhaps equally important was the unacknowledged conflict between the need to maintain concealment and the perceived need to warn the suspect not to try to escape out the back window. By deciding to shout orders at Mr. Stewart, thereby revealing their position, Officer Rabey and her partners chose to favor command presence over concealment, an especially fateful decision given the shooting

officer's belief that her position offered very little practical cover as a barrier to hostile fire. This tactical dilemma and possible solutions to it, such as requesting that the acting lieutenant in the front of the building warn Mr. Stewart against escape out the back, were never addressed by the Training Division Review or the Commander's memo.

AR-15 Certification and Training

This incident shows that there are many instances where it is prudent and useful to have an AR-15 rifle standing by even if SERT is not yet on the scene. The Bureau has recently implemented a new, more robust AR-15 qualification screening and training program involving a much longer training period than previously required, and including practical "shoot/don't shoot" scenarios.

Incident Commander's Role

The Bureau's experts wrote frankly about the supervision problems at the scene. The Training Division Review identified the acting lieutenant's decision, as incident commander, to personally telephone and hail the suspect, as an important deviation from policy that caused many other problems. The analysis pointed out that these delegation issues are now taught in Sergeant's Command School. A lieutenant arrived on the scene an hour into the incident. The Commander's memo also faults that lieutenant for failing to recognize the acting lieutenant's failure to delegate, concluding that the lieutenant should either have assumed the role of incident commander or advised the acting lieutenant to step back from the negotiator task.

Decision to Activate SERT

Even though the situation involved a presumed armed, barricaded suspect with possible hostages, the decision to call SERT was quite late, though PPB policy does not specify a time limit and gives great discretion to the incident commander. Bureau experts came to conflicting conclusions about whether the incident commander had waited too long to call SERT. We recommend that the Bureau consider making the policy more explicit in discouraging long delays before activating SERT.

Decision to Use Lethal Force

The Training Division Review often compares the decisions of supervisors with PPB policy and doctrine. It does not apply the same level of scrutiny to the decision by the shooter officer to shoot.

On its face, Officer Rabey's rationale seems speculative. The Training Division Review does not adequately address this, and instead adds some state of mind factors not articulated by the shooter. Much of her rationale is based on how poor the team's cover and position were. This raises a fundamental question of the quality of the tactical decisions in setting up the perimeter, all of which was done methodically over a relatively long time. These "set up" decisions, however, are not sufficiently scrutinized by the Training analysis.

Likewise, Officer Rabey's decision to shoot, as expressed in the Training analysis, is ultimately based on a suspicion that the suspect might be reaching for a gun in the closet and if he did, he might be able to turn around, aim and shoot it quickly at Officer Rabey and her partner, who were too close and without sufficient cover to be safe. This rationale for a pre-emptive shot may be an accurate recreation of the shooter's state of mind, but it is neither questioned nor examined by the Training Division as an adequate basis for use of deadly force under PPB policy or the law.

The Training analysis appears to search for a strategic justification for the shooting based on reaction time: "The Training Division teaches that action is always faster than reaction.… If Officer Rabey waited to see Mr. Stewart turn with a weapon from the closet, she would have been behind the reaction curve and there would have been a high probability of being shot given her position and reaction time." This may be a true statement of physiology, but it completely avoids the central value judgments at issue. Is the surmise that the subject might be about to obtain an unseen gun a reasonable one based on what was known of the subject and the circumstances up to that time? If he is in fact taking action to obtain a gun, is it reasonable to assume that there is a good chance he will try to use it against officers right away? These are particularly relevant questions in these circumstances because it was assumed that the subject had a gun from the outset of the incident based on the reports and background sounds of the initial phone call.

Communication Issues

Communication was generally good among the officers at the scene, with the possible exception of the information about the mother and son leaving the apartment. This information was broadcast in a timely fashion, and when interviewed by IA, Officer Rabey said she had heard that the mother and son were out the door despite having had her radio on low volume. To address this, Training reiterated a PARC recommendation that "AR-15 operators should be provided earpieces because of the positions they are routinely put in involving quickly evolving incidents with the potential for deadly force to be used." Some communications, moreover, were not conveyed to the rear. It appears that Officer Rabey was not aware that the incident commander was in on-and-off telephone contact with Mr. Stewart and that he had said that he was interested in changing his clothes. The Commander's memo observed that, under the circumstances, these mundane facts "may have changed Officer Rabey's perception of Stewart and the threat posed to her and other officers."

May 13, 2008 ◦ Jason Spoor

On May 13, 2008, at 8:26 p.m., East Precinct received a call from a complainant who claimed to have been in a house on NE Glisan four to five hours earlier when she heard a gunshot and then saw a man lying in a pool of blood with a gunshot wound to his head. A PPB officer was assigned the call and met with the complainant. She identified the shooting victim as well as the house, which was located in Southeast Precinct. When the officer drove past the house with the complainant, the house was dark and appeared to be unoccupied, though the complainant reported that the electricity in the house was turned off and so the darkness was not unexpected.

The officer called for a sergeant and backup. Two sergeants responded – one from Southeast Precinct and one from East Precinct – along with Southeast Precinct Officer Timothy Bacon and his trainee. East Precinct Officer Scott McCollister was not assigned to the call, but responded because he recognized the name of the alleged shooting victim as someone he knew to be a suspect in a homicide that had occurred two weeks prior. The original officer to whom the call was assigned contacted a Homicide detective and confirmed the name of the alleged victim. He also learned that Homicide was not interested in handling the call until officers confirmed someone had been shot and killed, and that the information provided by the complainant was not likely sufficient to obtain a search warrant for the house.

The group of four officers and two sergeants met at a park a short distance from the house and spent a significant amount of time attempting to gather information about the house or its occupants and discussing the situation and various options. The complainant's account of the incident remained consistent through repeated questioning, leading them to conclude she was reliable despite the fact she appeared to all of them to be "tweaking" on methamphetamine. The group ultimately decided they had an obligation to further investigate the possibility there was a dead or injured person inside the house on NE Glisan. They also concluded it was unlikely that anyone, let alone a suspect in that alleged homicide, would have remained in the house with the shooting victim. They made a plan to approach pursuant to their role as community caretakers.

Shortly after 10:00 p.m., nearly two hours after the complainant's initial call, the officers walked up to the house, intending to peer in the windows to see if there was a shooting victim inside. They were equipped with a diagram the complainant had drawn of the interior layout. As they got near, a man stepped

onto the front porch and immediately retreated inside in a manner that suggested he had spotted the officers. The team hastily took steps to contain the house by moving to various positions – the East sergeant and three officers covering one side and the rear, and the Southeast sergeant and the original handling officer on the other side. The Southeast sergeant made a request for additional cover officers to respond Code-3 (meaning assisting officers should respond with lights and sirens).

As numerous other units from both East and Southeast Precincts responded, the Southeast sergeant realized it was both undesirable to have so many lights and sirens approaching the scene and tactically unwise to have numerous officers driving right into the location with no idea what the call was about and where the threat was. As she put out additional radio traffic intending to limit the number of cover officers, shut down their sirens, and direct their positioning, the man, later identified as Jason Spoor, again stepped out of the house.

Officers immediately recognized that Mr. Spoor had a gun. He was holding it to his head and walking slowly backward, toward and eventually into the street. Officers repeatedly shouted commands to drop the gun, and Mr. Spoor shouted back, cursing at officers and indicating that his girlfriend was coming to pick him up. As he moved across numerous lanes toward the opposite side of the street, various officers had their guns trained on Mr. Spoor, including one officer with an AR-15 rifle. In their interviews with Detectives, each of these officers spoke about training scenarios during which they learned about the action-reaction principle, which asserts that Mr. Spoor could have pointed his gun at officers and fired rounds prior to their ability to react and shoot at him. In addition, officers discussed the threat Mr. Spoor – now considered a likely suspect in the earlier shooting reported to have occurred at the location – posed to residents in the surrounding neighborhood should he escape the containment. Each concluded they would have been legally justified in shooting Mr. Spoor, but did not because they were aware of their backdrop of vehicle traffic and residences.

Both Officers McCollister and Bacon were covering the rear of the house when Mr. Spoor emerged the second time. They both moved to positions near the front of the house when other officers announced that a suspect had come out of the house and they heard officers giving commands to drop the gun. By the time they reached positions at the front and side of the house and visually located Mr. Spoor, he was in the street and yelling back at officers.

As Mr. Spoor had nearly reached the other side of the three-lane street, Officers McCollister and Bacon, standing near each other but approximately 50 feet away from Mr. Spoor, each fired one round. Prior to shooting, each officer observed Mr. Spoor looking around as if trying to identify the positions of the officers shouting commands, in what they believed might have been an attempt to target a specific officer. McCollister stated that immediately before shooting, he saw Mr. Spoor take a little shuffle step, set his feet, and turn toward the officer's position at the same time he began to pull the gun away from his head. McCollister considered his backdrop – a tree and a car – and fired one round from his handgun. Almost immediately after McCollister fired, Officer Bacon also fired one round. Bacon's observations were similar to McCollister's. He said that, just before he fired, he saw Mr. Spoor straighten up and turn to look right at him and the officers near him. He also said that prior to that, he had been very concerned about his backdrop, but that Mr. Spoor had moved in front of a low wall and that he had a shot he believed did not pose a threat to residents. One of the officers' two rounds struck Mr. Spoor in the head, killing him instantly. The other round went into an empty car.

As officers were confronting Mr. Spoor, they also began to detect the smell of smoke and surmised that the house from which the suspect had emerged was on fire. Within minutes after the shooting, officers requested Portland Fire Bureau to respond. At the time, they did not know whether any additional suspects were in the house.

As Mr. Spoor lay on the ground, officers could see his gun near his feet, approximately four to five feet away. The two sergeants on scene did not coordinate a plan for taking Mr. Spoor into custody or dealing with the threat posed by the house,[3] but the East sergeant, who was closest to Mr. Spoor and very near Officers McCollister and Bacon, began to put together a team to approach Mr. Spoor. Someone had called for SERT to respond, but the sergeant opted not to wait for SERT officers. She said she was sure Mr. Spoor was dead by the way he had landed, but understood she could not make that assumption. She assembled a six-person custody team and instructed one officer to fire two less-than-lethal beanbag rounds at Mr. Spoor. Mr. Spoor did not respond to these

[3] The Southeast sergeant said in her Internal Affairs interview that she attempted to get on the radio to discuss the situation with her fellow sergeant, but that she got "stepped on" by others due to the volume of radio transmissions. To address this, the Training Division Review recommended that the Bureau produce a roll call video on radio discipline. The Bureau has not implemented this recommendation.

rounds, and did not comply with orders to show his hands. The custody team approached, handcuffed him, verified he had no pulse, and then left Mr. Spoor on the ground, retreating back to positions of cover. Paramedics had arrived, but the sergeant made the decision to stage them at the perimeter until the scene was secured. Fourteen and a half minutes elapsed between the time of the shooting and the time Mr. Spoor was handcuffed by the custody team.

Officers on scene continued to hold a perimeter around the house until SERT arrived, approximately 30 minutes after the shooting. SERT officers confirmed that Mr. Spoor was deceased and assisted the Fire Bureau in extinguishing the fire and clearing the house.[4]

Timeline of Investigation and Review

5/13/2008	Date of Incident
5/23/2008	Grand Jury proceedings
11/10/2008	IA report initially completed
12/2/2008	Case returned to IA for additional interviews
3/9/2009	Additional interviews completed (one interviewee had a scheduled 3/11/2009 vacation 12/4/2008 through 1/4/2009)
4/1/2009	IA Investigation completed
7/3/2009	Commander's Findings completed
10/21/2009	Use of Force Review Board

[4] Investigators did discover a deceased gunshot victim inside the house. The ensuing Homicide investigation concluded that Mr. Spoor was the suspect in that murder.

Analysis/Issues Presented

Development of a Plan

This scenario began when an officer was dispatched to an unusual call. Rather than rushing into a potentially dangerous situation, he called for assistance and spent time with responding officers and sergeants discussing and planning the best way to address the problem. After spending time with the complainant and verifying certain aspects of her story, officers developed an opinion that she was credible and that there may very well be a dead or injured person inside the house on NE Glisan. The officers approached the house with the intent of peering into the windows pursuant to their community caretaker responsibilities. Within minutes of officers' arrival, they were confronted with a barricaded suspect scenario as the individual later identified as Mr. Spoor emerged from the house and quickly retreated inside.

The officers' response was based on the faulty assumption that the suspect in the alleged shooting would have vacated the house on NE Glisan long before their arrival. While it was not unreasonable for them to have developed this expectation, it was unwise for them to fully develop a plan without accounting for the possibility it was not true. For example, as both the Training Division Review and Commander's memo note, officers could have conducted surveillance of the house, and may have seen signs of Spoor moving about. According to the Commander's assessment, they also should have consulted SERT. While the scenario as initially presented did not require a mandatory SERT call-up, a SERT officer would have discussed the options with the responding officers, helped to shape the tactical plan, and perhaps offered a limited deployment of SERT resources.

Communications Issues

The situation after Spoor retreated into the house became somewhat chaotic. Someone – likely the East sergeant – called for Code-3 cover as the officers dispersed to contain the house. A Multnomah County Sheriff's deputy (a former PPB officer) was not monitoring radio traffic but happened to be driving down NE Glisan on his way to a warrant service. He recognized some of the officers involved in this scenario and stopped to offer assistance. The deputy placed himself in a dangerous position in front of the house because he did not know anything about the situation officers were confronting. In response to the call for cover, "everyone and his uncle" started rolling to the incident with lights and

sirens. The Southeast sergeant got on the radio in an attempt to limit the number of cars responding and to tell them to shut off their sirens. The coordination efforts got no further before Mr. Spoor again emerged from the house with the gun to his head.

As the situation unfolded, numerous officers arrived on scene, with no knowledge of the threat presented. Because of the darkness, involved officers did not know where all the other officers were located. While the Training analysis and Commander's review both discuss the Sheriff's deputy's error in not monitoring the correct dispatch net and essentially stumbling into the middle of this call, neither of them discuss the potential crossfire issues created by the number of officers who responded knowing little about the nature of the call. The reviewers did not explore whether it would have been advisable or possible for the Code-3 cover request to have been more detailed amid the unavoidable chaos created by Mr. Spoor's emergence, retreat, and hasty re-emergence.

Post-Shooting Response

After the shooting, the scene divided naturally into two parts – the burning house and any potential threats within it, and Mr. Spoor lying on the ground with a weapon nearby. The East sergeant took command of the custody team without coordinating with her fellow sergeant. The Southeast sergeant believed she was in command of the entire scene and was surprised to see a team moving to take Mr. Spoor into custody. This highlighted the issue of the lack of clear command throughout this incident. Because the call was in her precinct, the Southeast sergeant stated she assumed the leadership role, yet it was never specifically determined who was in command and not entirely clear that the East sergeant had ceded authority to her counterpart. While they generally worked well together throughout this incident, as the Commander's findings memo recognized, they should have stated who was in charge at the outset in order to avoid later confusion.

Officers spent approximately 15 minutes planning and approaching the downed suspect, confirming he was dead with a gunshot wound to the head. The East sergeant, closest to the downed Mr. Spoor, decided not to wait for SERT to make this approach, believing she had sufficient resources to do it safely. The other sergeant disagreed with this decision, and stated in her interview she would have maintained cover on both Mr. Spoor and the house pending the arrival of a SERT team. The East sergeant's decision to move more quickly allowed officers to neutralize Mr. Spoor as a threat and, as importantly, would have provided the

opportunity to get medical attention to him had he still been alive. Unfortunately, neither the Commander's memo nor the Training Division Review definitively resolves the implicit dispute between the two sergeants. Both documents discuss the communication breakdowns between the sergeants at this point in the decision-making, but neither states a clear preference for one approach over the other. The Use of Force Review Board memo does not present an opinion on the post-shooting response, but does recommend that the Bureau "consider forming a workgroup to consider the use of ballistic shields in supervisor vehicles." If such a workgroup was formed, it did not provide for the acquisition of ballistic shields, as this again became an issue in the aftermath of the Aaron Campbell shooting, discussed below.

Quality of Investigation and Review

Positive Impact of Review Process

The investigations by Detectives and Internal Affairs were generally thorough and well done, notwithstanding the issues presented below. Internal Affairs investigators completed their initial investigation fairly quickly – within six months of the incident – but that investigation was not sufficiently thorough. The Bureau's review mechanism functioned well here, as an Assistant Chief recognized that the original handling officer and the two sergeants needed to be interviewed by IA investigators. While Detectives had interviewed all three, those interviews did not focus enough on the planning, coordination, and command aspects of this incident. It was reasonable for IA to rely on Detectives' interviews for the large number of witness officers; however, the Assistant Chief was correct to insist on IA interviews of these three key witnesses.

Delays in Investigation and Review

Unfortunately, because of scheduling issues, the additional witness interviews created a four-month delay in final completion of the investigation. The Commander's review took an additional three months. It took an additional three months for the case to be scheduled and presented to the Use of Force Review Board, which concluded the shooting was within policy and recommended no discipline for the involved officers. While we appreciate the very thorough manner in which the Bureau reviewed this incident, it would have been better if

the review process had been concluded consistent with the Bureau's internal deadlines.

Ineffective Use of Crime Scene Diagram

As in other cases discussed in this report, neither Detectives nor IA investigators make clear the locations of various officers during the incident. While they sometimes refer to diagrams or photos when questioning witnesses, those diagrams are not attached to the interview transcripts, so that the record does not clearly document where people were positioned.[5]

[5] The Bureau has informed us of its purchase of a technologically advanced system for the preparation of three dimensional crime scene diagrams that will be operational later this summer for use in officer-involved shooting investigations. It will be interesting to see whether system meets the Bureau's expectations for improving the effectiveness of crime scene documentation.

January 29, 2010 ◦ Aaron Campbell

On January 29, 2010 at 4:22 in the afternoon, North Precinct dispatch received a 911 call from a woman concerned about her niece and her niece's three children. She said her niece's boyfriend, Aaron Campbell, was armed, suicidal, and had attempted to kill himself earlier. A PPB officer responded to do a welfare check at the niece's apartment at 128th and NE Sandy Boulevard. Outside the apartment, while waiting for a cover officer, he was approached by the niece's father, who told him his daughter's boyfriend was distraught about losing his brother the night before and he was concerned because his daughter was not answering her phone. While the handling officer was speaking with the father, a number of backup officers arrived and began to contain the property by taking perimeter positions. Because no sergeant had yet picked up on the serious nature of the call and assumed command, one of these backup officers requested a sergeant to respond. As this team was gathering information, around 40 minutes after the 911 call, the niece, Mr. Campbell's girlfriend, walked out of the apartment.

The original handling officer spoke with the girlfriend. She told him Mr. Campbell's mental state had been worse the night before, and that she did not believe him to be a threat. This information contradicted the information obtained from the 911 caller, and the officer said later he was not sure he could trust the girlfriend, who might have been trying to protect Mr. Campbell. The original handling officer did not relay this information to other officers at the scene. The girlfriend was moved to the perimeter as the officers discussed how best to get the three children out of the apartment. They attempted to call Mr. Campbell, but were unsuccessful. They then realized the girlfriend had been receiving text messages from Mr. Campbell, and the original handling officer retrieved her cell phone. The most recent message from Mr. Campbell stated "I ain't playing. Don't make me get my gun." The officer broadcast this information over the radio and gave the cell phone to the officer who had been assigned the task of communicating with Mr. Campbell.

The communicating officer began exchanging text messages with Mr. Campbell as other officers arrived at the scene, coordinated by the handling sergeant. A second sergeant also arrived on scene to assist. Another officer requested a canine officer and an AR-15 operator, and officers responded to fill those respective roles. The handling sergeant assigned an officer to operate a beanbag

shotgun. As the handling sergeant coordinated resources, established a perimeter, and assembled a custody team, the second sergeant – a member of the Hostage Negotiation Team (HNT), though not on scene in that capacity – worked with the communicating officer as he communicated with Mr. Campbell. Over a phone line garbled by static, Campbell told this officer that he wanted officers to go away and leave him alone. The officer responded that they needed to make sure the kids were safe. Mr. Campbell did not respond but simply hung up the phone. Within a minute or two – approximately 30 minutes after the girlfriend left the apartment – the children walked out.

At this point, the handling sergeant believed they should ask Mr. Campbell to come out of the apartment with the intention of getting him whatever mental health help he needed. There was some discussion about what the strategy should be if he came out and tried to run – either away or back into the apartment. The handling sergeant believed they should use less-than-lethal force – beanbags or the canine – to stop him. The second sergeant questioned this assessment, but no consensus was reached or expressly communicated to the rest of the officers at the scene.

The handling sergeant also stated it was her intent to have officers just walk away if Mr. Campbell refused to exit the apartment. Though he reportedly had a gun, Mr. Campbell had not committed any crime or demonstrated a willingness to hurt others. Communications were going well, and she believed it might be sufficient to get a promise from Campbell over the phone that he would not hurt himself and then comply with his wish to be left alone.

The second sergeant again disagreed. He believed the officers had a responsibility to have a face-to-face conversation with Mr. Campbell before they left, so they could be confident he had no intent to hurt himself or others. He was concerned because Mr. Campbell was in his girlfriend's apartment, not his own home, and he wanted to ensure she and the kids had a place to go and would not have to return to a potentially dangerous situation. He also was concerned about the residents in neighboring apartments.

While the sergeants were discussing these issues, in what was described as a tense but not argumentative way, a lieutenant and captain were responding to the scene. They arrived and asked the handling sergeant to brief them on the incident. She left the alcove where she had been working with the communicating officer and the second sergeant, and went to the perimeter location to brief her commanding officers. While she was away, the second sergeant told the communicating officer

to call Mr. Campbell and ask him to come out and talk with officers. As he did when they asked him to make sure the kids were safe, Mr. Campbell did not respond but simply hung up the phone. The officer did not have the opportunity to talk to him about how he should come out – to walk slowly, leave the gun behind, and keep his hands up. Instead, Mr. Campbell just walked out within seconds after he hung up the phone – approximately 33 minutes after the children had come out and just over an hour after his girlfriend had exited. No one communicated to the custody team that they had asked Campbell to come out.

Officer Ron Frashour was the designated AR-15 rifle operator and was in a position behind cover 60-70 feet from the apartment door. The officers assigned to the beanbag shotgun and canine were similarly positioned. Mr. Campbell emerged with his hands behind his head and began walking backwards or sidestepping toward the officers while facing away from the officers. The accounts about Mr. Campbell's pace vary among the officers, but he seemed to be moving purposefully and not heeding the beanbag officer's instructions to slow down. This officer then ordered him to stop and he stopped. He ordered Campbell to walk slowly backwards toward the officers and Campbell followed this command. He again ordered him to stop and he again complied. At this point, Campbell was approximately 15-30 feet from the patrol car behind which the beanbag officer and Frashour had taken cover. The beanbag officer intended to direct Mr. Campbell into a prone position on the ground so that other officers could take him into custody. He warned Campbell he would be shot if he didn't do exactly as he was told. Mr. Campbell turned slightly to look at the officers and responded, "go ahead and fucking shoot me," or words to that effect.

The officer then twice ordered Campbell to put his hands straight up into the air, but Campbell kept his hands on the back of his head. The officer fired a beanbag round, striking Campbell in the buttocks. According to this officer, Campbell then began to pull his hands off his head and began to step forward, and the officer again deployed the beanbag shotgun, again striking Mr. Campbell. Campbell then began running back toward the apartment, and the officer fired four more beanbag rounds at him as he ran.

Officer Frashour was assigned the role of lethal cover and had positioned himself near the beanbag officer behind a patrol car. He was listening to radio traffic via the radio attached to his lapel.[6] He was surprised when Mr. Campbell came out of

[6] The Bureau recommends that AR-15 operators wear earpieces to ensure they receive all radio updates. Frashour stated he is well conditioned to using his lapel radio to get

the apartment, and was concerned with the speed at which he began walking toward them. Because Mr. Campbell had his hands on his head and had complied with commands to stop, Frashour was again surprised when his fellow officer fired the beanbag round. After that first round, Frashour observed that Mr. Campbell stumbled forward, but quickly regained balance and kept his hands on his head. According to Officer Frashour, after the second beanbag round, Campbell reached his left hand down into his pants as he began to run away.[7] Frashour believed Campbell was reaching for a gun and was concerned Campbell would reach a position of cover and begin shooting at police officers. Frashour believed he was justified in using deadly force and fired one round from his AR-15 rifle. This round struck Mr. Campbell in the lower middle back, fatally wounding him.

As Mr. Campbell ran away from the officers, the canine officer made the decision to deploy his dog to stop Mr. Campbell from either getting back to his apartment or to a position of cover behind the car parked in front of the apartment. He believed Mr. Campbell may have had a gun and wanted to prevent him from gaining an advantage over the officers. Before the dog reached Mr. Campbell, however, Officer Frashour fired his rifle, dropping Campbell to the ground. The dog bit Campbell briefly, and the canine handler called him back.

Officers had a brief discussion about whether it would be safe to approach Mr. Campbell to take him into custody and render medical aid, but because his hands were underneath his body and they believed he may have a gun, the second sergeant made the decision not to approach and to instead activate SERT. A SERT team responded and approached and handcuffed Mr. Campbell. Approximately 38 minutes after the shooting, a SERT medic determined he was dead. Detectives later entered and searched Mr. Campbell's apartment, finding a small handgun inside a sock on the top shelf of a linen closet.

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updates, and generally does not wear an earpiece. Because the issue in this case was the failure to broadcast updates rather than Frashour's inability to hear them, Frashour's practice of not using an earpiece did not affect the outcome here.

[7] Some witnesses corroborate that Mr. Campbell reached back and some do not. The civilian witnesses who report seeing this reach generally speculate that he was reaching to that area because that is where he had been shot with the beanbag round.

Timeline of Investigation and Review

1/29/2010	Date of Incident
2/4/2010 - 2/9/2010	Grand Jury proceedings
7/6/2010	IA Investigation completed
7/14/10	Training Division Review completed
7/30/2010	Commander's Findings completed
8/26/2010	Use of Force Review Board

Analysis/Issues Presented

Lack of Communication

Poor communication at the scene of this incident led officers to make judgments and decisions based on incomplete information, and to interpret events in vastly different ways. For example, officers responding to the scene knew from dispatch that Mr. Campbell had tried to kill himself and may be considering "suicide by cop." However, when the original handling officer talked to Mr. Campbell's girlfriend and learned that the suicide attempt had occurred the prior night and Mr. Campbell was reportedly doing much better at the time, this information was not conveyed to all officers. Likewise, Mr. Campbell's text message in which he wrote "don't make me get my gun" was quickly broadcast, but the accompanying message that he just wanted to be left alone was not disseminated.

The officer communicating with Mr. Campbell and the two sergeants were operating out of an alcove near the apartment. While a report was broadcast that communications were progressing, no one assumed the responsibility of communicating any specific information about those discussions to the custody team. This failure led members of the custody team to interpret events as escalation when they were really signs of cooperation. For example, the children came out of the apartment immediately after the communicating officer suggested

to Mr. Campbell the police could not leave until the kids were safe. Not knowing about this suggestion, members of the custody team interpreted their exit as a potential escalation – Mr. Campbell wanted to get the kids out of the way before he had a shoot-out with police. Similarly, no one communicated that the officer had asked Mr. Campbell to come out of the apartment, so that other on-scene officers were surprised when he came out, and could not appropriately interpret his emergence as a sign of compliance with police demands.

In addition to not knowing the status of negotiations, the custody team did not receive clear guidance or direction from the incident commander, the handling sergeant. She did a good job coordinating resources and, according to her articulation of the event, had made plans for different contingencies. However, she did not effectively communicate this planning to the officers on scene. For example, if Mr. Campbell came out of the apartment and then attempted to run back in, she intended to direct less-lethal force options, including the canine, to prevent him from doing so. She discussed this with the second sergeant, and perhaps the canine handler, but not the other members of the team, who should have been aware of this plan. Both the Training Division Review and the Commander's memo thoroughly examine these communication lapses, which factored into the recommendation that the sergeants should receive discipline for their roles in this incident.

Lack of Communication and Cooperation between Sergeants

One sergeant was handling the call when the second sergeant arrived to assist. This second sergeant asked what he could do to help, and the handling sergeant did not give him an assigned task. Given his HNT experience, he took it upon himself to assist with negotiations, but he did not see it as his role to communicate directly with other officers because the handling sergeant was the incident commander. Her reluctance to relinquish control of any aspect of this incident led to some of the later communications failures.

The two sergeants sometimes disagreed over tactics and planning, most notably over the decision about whether to walk away or insist that Mr. Campbell come out of the apartment. The discussion grew tense but not argumentative. When the handling sergeant left the alcove to report to the lieutenant and captain, the second sergeant had the communicating officer call Mr. Campbell and ask him to come out. While he acknowledged that the other sergeant was still incident commander at the time, he did not notify her of this decision, and did not relay the information to any others on scene.

Both the Training Division analysis and the Commanders' review thoroughly examined the lack of communication and coordination at the scene of this incident and found the sergeants' performances to be inconsistent with training and out of policy. Following the Use of Force Review Board, both received discipline.

Failure to Seek a SERT Consult

This incident did not meet the specific criteria for a mandatory SERT/HNT call-up. Nonetheless, the Commander's memo notes it would have been prudent for the handling sergeant to call a SERT commander to discuss the situation and see if there were resources available to her that she had not considered. At a minimum, as she and her fellow sergeant got into disagreements over tactics and decision-making, a SERT or HNT consult might have proven valuable. In fact, in our discussion with SERT/HNT members, we learned that a number of team members were hanging around the office that evening, monitoring the radio broadcasts and anticipating a possible call-up.

Role of the Lieutenant and Captain

None of the three sergeants on duty in North Precinct at the time heard the initial call go out, but were at the station performing administrative functions. The handling sergeant heard an officer's request for a sergeant response 25 minutes after the initial call and responded immediately. Both the lieutenant and captain heard the initial call, but did not ensure that a sergeant was responding. Following this incident, the Bureau attempted to address this issue by requiring sergeant notification and response to all calls involving armed suicidal subjects, and those to which four or more units respond.

When the lieutenant and captain arrived at the scene, they requested a briefing from the handling sergeant. She was busy with other tasks at the time, but nonetheless felt like she could not ignore what she interpreted to be an order from a commanding officer, so she left her location to go to the perimeter to provide a briefing. Again here, the failure to communicate injected an unnecessary level of stress and dysfunction into the situation. The sergeant was frustrated by the request to brief her supervisors in person, but rather than express to them why she could not leave, or alternatively send the second sergeant to do the briefing, she left her post at a critical point in the incident, creating confusion as to who was acting as incident commander in her absence. This, too, was discussed in the Commander's memo as a factor in the decision to recommend discipline for the sergeant.

In addition, the Bureau has modified its Sergeant's Command School curriculum to include additional training in Critical Incident Management and has added two extra days of in-service training for sergeants to its annual training requirement. Our review of the curriculum for the Critical Incident Management training demonstrated the Training Division's willingness to use this shooting as a learning tool, as many of the points raised and examples given in that training are pulled directly from this incident.

Decision to Use Less-than-Lethal Force

The Training Division prepared a 55-page Training Division Review containing a detailed description of events and officers' descriptions as well as a thoughtful analysis of the incident. The level of detail included in the written analysis demonstrated that its authors had reviewed all available materials to develop a command of the facts. The analysis determined the officer's decision to deploy his beanbag shotgun rather than continue to talk with Mr. Campbell in an attempt to de-escalate the situation was not consistent with training. The review by the North Precinct Commander was timely and thorough, and concluded that this use of force was out of policy. The beanbag officer was disciplined following the Use of Force Review Board hearing.

Following the shooting of Mr. Campbell and another incident during which a juvenile was shot with beanbags, the Bureau assembled a Review Level Committee on use of the beanbag shotgun. The Committee recommended and the Bureau implemented a mandatory annual 10-hour in-service training for the all certified beanbag shotgun operators. This training includes two hours of classroom time, practice with the manipulation and firing of the weapon, and scenario-based training to emphasize when the weapon should and should not be deployed.

Decision to Deploy Canine

The Training Division Review also addressed the canine officer's decision to deploy his dog in an effort to apprehend Mr. Campbell as he ran back towards his apartment and concluded it was consistent with training. The Commander's review and the Use of Force Review Board concurred with the Training Division analysis and found that the use of the canine in this situation was within policy.

Decision to Use Lethal Force

Unlike earlier cases we discuss in this report, the Training Division Review and the Commanders' memo in this case thoroughly addressed the questions surrounding Officer Frashour's decision to use deadly force. In answering the critical questions of why Officer Frashour deployed deadly force on Campbell and whether that use of deadly force was consistent with training, the Training analysis thoroughly explored the officer's state of mind – as evidenced by his IA interview and grand jury testimony – as well as other tactical options presented. The Analysis noted that Frashour was so focused on the perceived threat Campbell posed that he did not properly focus on his own decision making process, was not sufficiently aware of what was happening around him, and did not consider the possibility that Campbell's actions could be interpreted in a way that mitigated the threat. For example, some witnesses saw Campbell's hand moving to his lower back as a response to the pain of being struck by beanbag shotgun rounds, but Frashour did not consider this possibility and never considered the possibility that Mr. Campbell was unarmed. Because Officer Frashour did not adapt to the changing dynamics of the situation and did not employ confrontation resolution skills he should have developed, the Training analysis concluded that his performance was not consistent with training.

The Commander's memo heavily cited the Training Division Review and concluded that the use of deadly force was outside of policy because it was not reasonable to believe that Mr. Campbell posed an immediate threat of death or serious physical injury to the officers at the time Frashour fired his AR-15. The Use of Force Review Board concurred. Based on our reading of the investigative record in this case, we believe that the Training Division Review and the Commander's memo, taken in combination, presented a thorough and valid identification of the issues relevant to evaluating the decision to use lethal force. Furthermore, we found these analyses to be persuasive backing for their conclusion that the decision to shoot was inconsistent with Bureau training.

In a widely publicized decision, the Bureau decided to discharge Officer Frashour. A state arbitrator very recently overturned the Bureau's decision and ordered Frashour reinstated to his position as a PPB officer. We have not examined that decision, nor do we believe it would be appropriate to comment on the arbitration process at this time, as the City's appeal of the arbitrator's ruling is still unfolding.

Following the shooting of Mr. Campbell, then-Chief Sizer convened an AR-15 Review Level Committee to examine the selection, certification, and training of AR-15 operators and recommend any necessary changes. The Committee recommended and the Bureau implemented significant changes. Beginning in 2011, the review criteria for AR-15 operators was expanded to include an examination of an applicant's training records, use of force numbers, prior administrative investigations, and questionnaires sent to sergeants and instructors regarding the applicant's judgment and other criteria. The length of the certification class was expanded to six 10-hour days, and the annual in-service training is two days. Both training classes include shoot/don't shoot scenario training. The rigorous demands of the new training and certification process have resulted in a 25-30% failure rate among participants.

Post-Shooting Response

It took officers 38 minutes to approach Mr. Campbell to check his vital signs. Despite the fact the canine had applied a sustained bite and Mr. Campbell exhibited no response, officers at the scene determined it was unsafe to approach Mr. Campbell because they could not see his hands. The second sergeant activated SERT and waited for those officers to take Mr. Campbell into custody. While this response was found to be consistent with PPB policy and training, according to the Bureau, this incident served as a "catalyst for change" in the Bureau's expectations regarding handling downed suspects. Within one month of this shooting, all sergeants' cars were equipped with ballistic shields. Within three months, all officers had received four hours of in-service training in the use of this tool to safely approach and take into custody injured subjects who may be armed, including the practice of handcuffing injured subjects and the reasons why it may be important to do so.

Quality of Investigation and Review

Investigation by Detectives and Internal Affairs

This case was meticulously and thoroughly documented, both by Detectives and Internal Affairs. Investigators prepared a detailed timeline and analyzed the radio traffic. In addition to extensive photographs and detailed diagrams, investigators also made use of a seven-page "word picture," in which a detective documented the scene by describing everything he could see as he walked the scene.

One thing not done optimally by either group of investigators is the documentation of where various officers and witnesses were positioned. They used diagrams or photos and often had officers mark their locations and the positions of others, but did not attach those diagrams to the interviews, limiting the ability of reviewers to understand the layout of the scene. In our communications with Bureau leaders in preparation of this report, we learned that IA agrees with this critique and has adopted the practice of having witnesses document their positioning and of ensuring inclusion of that documentation in the investigative file.

Also, as we note above, the use of the East County Major Crimes Task Force to assist in interviewing sworn and civilian witnesses in officer-involved shooting investigations is problematic. Their use here was not as extensive or problematic as in the Perez case, but we did find that some interviewers from the Task Force lacked familiarity with the incident and the location in a way that impacted the quality of the interviews.

Efforts to Avoid Leading Questions

Internal Affairs investigators made obvious and notable efforts to avoid leading questions. In this case in particular, investigators also exhibited no hesitation to ask the hard questions, including questions that went directly at the officers' justification for uses of force. The result was a thorough investigation with no indication of bias.

Use of Telephone Interviews by Internal Affairs

Internal Affairs investigators conducted all non-sworn witness interviews by telephone. These interviews were largely ineffective. Because investigators could not show them diagrams or photos over the phone, witnesses could not accurately convey where they stood at the time of the incident or how well they could see events unfolding. In addition, these interviews were generally redundant of the Detectives' interviews and, in some cases, the witnesses' grand jury testimony. IA should commit to conducting in-person interviews of all relevant witnesses. At the same time, IPR and other reviewers should remain flexible regarding the number of interviews that need to be conducted. Here, Detectives did a good job of locating and interviewing all witnesses. Many of these witnesses testified before the grand jury. By the time IA interviewed them, most had little or nothing to add. During the course of our review, we had conversations with IA leaders on this topic, and understand that it is now current

practice to interview witnesses in person. Following a discussion of our preliminary recommendations, the Bureau drafted a new Standard Operating Procedure mandating that practice, absent extenuating circumstances.

Recommendation 7: Except where prevented by documented hardship, IA investigators should maintain the practice of conducting in-person interviews of all relevant witnesses.

Detailed and Complete Training Division Review

As noted above, the Training Division prepared a 55-page Training Division Review containing a detailed description of events and officers' descriptions as well as a thoughtful analysis of the incident and numerous recommendations for improving the Bureau's response in future similar incidents.

We are aware that the Training Division Review in this case was a source of controversy among Bureau members. Two lieutenants were assigned the task of preparing it. Ordinarily, they would have presented it to their captain for approval. In this case, though, the captain of Training Division at the time had been the captain of North Precinct on scene as the situation unfolded. Because his performance was an issue for discussion, it was not appropriate for him to supervise the preparation of the analysis. Therefore, an Assistant Chief stepped in to the supervisor's role and ultimately approved the Training Division Review prepared by the two lieutenants. These two lieutenants rigorously analyzed the relevant issues, a fact particularly notable when compared with the analyses in cases discussed earlier in this report. We caution the Bureau against letting the controversy surrounding this case lead to a reversion to the prior, more reserved style of Training Division Review.

Thorough and Timely Internal Review

The review by the North Precinct Commander was timely and thorough. In addition to analyzing the individual involved officers' performances, he provides recommendations for the improvement of dispatch protocols, Critical Incident Management training for officers and supervisors, and the Bureau's practices regarding the approach and handcuffing of downed suspects.

March 22, 2010 ◦ Jack Dale Collins

In the mid-afternoon on March 22, 2010, a woman walking in the Hoyt Arboretum saw a disheveled man who appeared to be drunk and homeless following her. She felt threatened and reported this to a volunteer worker at the reception desk. The volunteer immediately conveyed this information to a supervising employee of the Arboretum. The supervisor alerted a manager and they walked over to the reception desk to contact the volunteer. By that time, a second woman had come in to report a disturbing encounter with what sounded like the same man. She walked out from the reception desk to her car in the parking lot and the manager followed and talked to her. She described being approached by the man on a path in the Arboretum. The man said, "I'm going to kill you." Her young son who was further down the path had received the same threat from the man. The boy thought he saw blood on the man's hands or shirt. During this conversation with the manager, the second woman gestured toward the man, who was now across the parking lot. The supervisor, who had remained back near the reception area, saw the gesturing and concluded that that this second woman had also had an encounter with the disheveled looking man similar to the one described by the first woman.

The supervisor called 911 and reported that "an intoxicated fellow…possibly a transient…is threatening people on the trails" and described the man's age, build and clothing. The operator asked if the man was "physically trying to harm anyone…or just kind of yelling at people?" The supervisor repeated that a couple of women said he had threatened them. The operator pressed for more detail, asking what the man had specifically said, but the Arboretum supervisor replied, "I didn't get that yet."

Officer Jason Walters was on duty when he saw the dispatch on his patrol car's Mobile Digital Computer, indicating that a drunken transient was harassing and yelling at passersby, including one female who said he had threatened them. Because he was familiar with the Arboretum and acquainted with some of the homeless persons that frequent the area, he decided to respond to the call. On his way, he called for the "CHIERS wagon" – a van from a detox facility where people who are intoxicated in public can go to eat, warm up, and sober up – to respond to the Arboretum to assist him. He then called the Arboretum supervisor on his cell phone to get more information. The supervisor characterized it as a "serious situation" and said that the man had moved from the parking lot to one of the restrooms of the visitor center, but did not add any more details.

When Officer Walters arrived at the Arboretum approximately nine minutes after seeing the dispatch, the supervisor and the manager met him at his patrol car and confirmed that the man was still in the bathroom. It is not clear whether the manager had conveyed the additional details from the second woman – that the man had said "I'm going to kill you," and may have blood on his hands or shirt – to the Arboretum supervisor. If he did, it appears that neither of them conveyed this information to Officer Walters when they conferred with him upon his arrival. They confirmed that the man was still in the bathroom and pointed to the correct one. Officer Walters put latex gloves on, expecting that he might be taking an intoxicated person into custody or to a detox center.

Officer Walters approached the restroom with his gun holstered. He knocked but got no response. Shortly after he knocked a second time, the door opened outward and the officer was immediately confronted by a man walking toward him with an X-acto razor knife in his left hand and blood on his hands, neck, beard and clothing. Contrary to his expectations, Officer Walters did not recognize this man as one of the transients familiar to him in the area. He would later be identified as Jack Dale Collins. The X-acto knife was pointed upward and toward the officer. Walters backed up and called on his uniform mounted radio for cover officers to respond Code-3 (immediately, with lights and sirens). Officer Walters drew his firearm and walked backwards shouting, "Drop the weapon," or "Put that down," and "Get down." He repeated these orders several times. Mr. Collins did not comply but said, "No, I am not going to do that. I won't," and continued to walk forward in a deliberate, slightly crouched side step with the knife in front of him. After backing up approximately 25 feet, the officer fired two rounds at Mr. Collins, who did not react except to walk in a small loop then return to the same position confronting the officer and walking toward him. Officer Walters shouted, "Drop the knife" a few times very loudly, and then fired two more rounds. Mr. Collins dropped to the ground and did not move.

Officer Walters broadcast that he had fired shots and injured a person and requested emergency medical services. He broadcast directions to responding officers who might not know the area well. He kept his weapon trained on Mr. Collins until officers arrived four minutes later. The responding officers handcuffed Mr. Collins four minutes later. Approximately one minute after that, medical personnel determined at the scene that Mr. Collins was deceased.

Timeline of Investigation and Review

3/22/10	Date of Incident
4/1/10 - 4/2/10	Grand Jury proceedings
7/23/10	IA investigation completed
11/30/10	Training Division Review completed
3/6/11	Commander's Findings completed
5/18/11	Police Review Board

Analysis/Issues Presented

Lack of Information Prevented Effective Planning

The Training Division Review and the Commander's Findings imply that, had he been aware that Mr. Collins had threatened to kill at least two people and might have blood on his hands or clothing, Officer Walters would have waited for cover officers before approaching the suspect and would have brought a bean bag shotgun with him. Indeed, this is what Officer Walters himself surmised, with understandable regret that he had not been aware of all the known facts before heading into the bathroom alone. Such preparation might have given the officers the tools to subdue Mr. Collins without shooting him. This truism, however, ignores another common wisdom – that such instances of information drop-out and miscommunication, especially at the nexus between civilian witnesses and dispatchers or patrol officers, are so commonplace in police work as to seem inevitable. The Bureau's ability to make civilians better witnesses is minimal. It should therefore work to improve those things it has control over. In this case, the Bureau can continue to improve its monitoring of and services to identified indigent and mentally disturbed citizens. The Bureau also can emphasize to BOEC the importance of training 911 operators to be especially proactive in obtaining relevant facts from civilian witnesses. At the same time, the Bureau should train its officers to ask questions and solicit information from dispatchers

rather than assuming the dispatcher has conveyed all relevant and available information.

Effective Canvass for Witnesses

There were a number of civilian witnesses to all or part of this incident. The canvass to identify them was thorough and the handling and separation of the witnesses before they were interviewed by Detective Division was appropriate. Unfortunately, the first woman who had notified the Arboretum personnel of Mr. Collins' behavior could not be identified or located.

Effective Post-Shooting Response

According to the Medical Examiner, Mr. Collins died from internal bleeding within a minute of the shooting. Officer Walters and other PPB officers did not, of course, know that at the time. Their efforts to get to the scene quickly and to approach and secure the downed suspect so that he could be attended to by paramedics contrast with the very long delays in obtaining medical attention immediately after some of the other shooting incidents discussed in this report.

Use of Grand Jury Testimony

We note that the Training Division Review and the Commander's Findings cited the grand jury proceedings as one of the sources they reviewed. The grand jury process, which, in this case was both extensive (23 witnesses) and prompt (occurring one week after the shooting) is an invaluable resource for incident reviewers. We commend the Bureau for recognizing this and including this evidence in their internal evaluations.

Unwillingness to Explore Tactical Alternatives

Both the Training Division Review and the Commander's Findings observed that Officer Walters, after backing up 25 to 30 feet, was running out of room to retreat. It seems clear from testimony that this was Officer Walters' perception, but it is unclear from the police reports and attached photos and diagrams why he did not have reasonable avenues of retreat. The Training analysis focused on whether Officer Walters' decision to use lethal force was reasonable and consistent with PPB training. The training and tactics experts who wrote the report did not consider any alternative actions, uses of force or angles of retreat except to describe what Officer Walters said was going through his mind at the time. This reluctance to appear to second guess the actions of a Bureau officer who has made

these decisions under difficult circumstances in a rapidly evolving incident is understandable, but it abdicates part of the instructive role of the Training Division Review. Training analyses should indeed exercise the 20/20 vision of hindsight and explore alternative scenarios without fear of appearing to hold every officer to an impossible ideal.

Factual Error in Commander's Findings

The Commander's Findings accurately pointed out that, while Mr. Collins had verbally threatened to kill the second woman and her son, this specific threat was never conveyed to BOEC or to Officer Walters. It also states correctly that no witnesses had seen Mr. Collins with a weapon before the officer encountered him outside the bathroom, but the memo asserts incorrectly that no witnesses saw blood on Collins prior to the officer encountering him. According to his mother, the young boy had seen blood on Mr. Collins' hands or clothing when they encountered Collins on the trail. This information, however, was not conveyed to the officer, so that the impact of this mistaken conclusion on the analysis is minimal.

Delay in Review Process

It took 14 months for the entire investigation and internal evaluation process to run its course between the shooting incident and the final evaluation by the Police Review Board. Another month passed before the involved officer was informed that the use of deadly force had been determined by the Bureau to be within policy. The investigations by Detective Division, the grand jury proceedings, and even the IA investigation were all completed within four months of the shooting. Unfortunately, the Training Division Review took almost four additional months, and the Commander's Findings took an additional three months. The case then sat for more than two months pending the scheduling of the Police Review Board. This is a slow pace for a case without extraordinary factual complications or a large number of employee witnesses. The Bureau undermines the potential remedial impact of its own tactical and procedural analysis by delaying the outcome for such a long period of time. Moreover, it is inefficient and demoralizing to withhold the shooter officer's fate for a long period of time. We are aware that turnaround time for some cases has been even longer – in some cases much, much longer. We are also confident that the Bureau can find a way to speed the review process, while maintaining the same commitment to detail and stakeholder input that it has shown recently.

SECTION TWO

Common Themes and Issues

Delays in Interviewing Involved Officers

In our review of the in-custody death of James Chasse, we noted the delay in interviewing the involved officers and expressed concerns that such delays affect the quality and integrity of the fact gathering process. As detailed below, those same delays are evidenced in each of the seven shootings we have reviewed. From a delay of at least one day to the longest gap of seven days, involved officers are not interviewed contemporaneously with the incident.

As we stated in our review of the Chasse in-custody death, the inability to obtain the officers' version of events contemporaneously with the incident hinders the fact gathering process and creates skepticism among some that the eventual statement provided by the officers may be potentially tainted by exposure to other sources of information about the incident either through inadvertence or collusion.

In addition, the trend in more recent fatal shootings is for officers, upon advice of counsel, to decline to provide voluntary statements to detectives. As a result, any advantage of affording officers a couple days delay so that a voluntary statement can be obtained no longer exists. And, as noted above, even in the cases in which officers agree to voluntary interviews, those voluntary interviews similarly do not

occur on the date of the incident. The "48-hour rule" dictated by the current Bureau labor contracts continues to impede the Bureau from obtaining even a compelled timely version of what occurred from the involved officers.

One idea the Bureau has put forward to ameliorate some of the deficit in timely information from officers is to require officers to make a public safety statement. A public safety statement is intended to provide on-scene supervisors a way in which to obtain vital information from involved officers so they can devise an effective public safety response. Following a critical incident such as an officer-involved shooting, there is almost always a need for the first supervisor arriving on scene to formulate a response plan. The supervisor needs to know whether any officers or other individuals are injured, whether any suspects remain at large, and whether any rounds went down range and may have struck and entered nearby businesses or residences. For that reason, many law enforcement agencies instruct supervisors to obtain public safety statements from the involved officers to gather this critical information. Because the interest in obtaining this information from involved officers is routine, these statements should be considered voluntary statements in the same way that a police report is considered to be a voluntary statement of the officer.[8]

While we agree that the routine collection of a public safety statement is a key protocol missing from the way in which the Bureau responds to officer-involved shootings, we do not believe the implementation of such a protocol would rectify the delay in obtaining the involved officers' recollection of events because the amount of information obtained in a true public safety statement is too limited and not a full and detailed account of the incident. Should the Bureau implement a public safety statement requirement, it should be true to the above-stated purpose to primarily serve the interests of public safety in those first moments after an officer-involved shooting.

We also believe it is time for the Bureau and the City to end the 48-hour rule that exists in the current labor agreement so that full and contemporaneous accounts of these critical and sometimes controversial incidents can be obtained from the involved officers. In our view, the next time the labor contracts become due, July

[8] The Bureau has prepared a draft deadly force policy that includes a public safety statement requirement as part of the Bureau's standard investigative protocol. We have been informed that the Bureau intends to enter into initial discussions with the District Attorney's Office and the bargaining units this year with regard to the feasibility of implementation of a public safety statement in deadly force investigations.

1, 2013, the elimination of the 48-hour rule should be one of the primary objectives of any future collective bargaining.

Recommendation 8: The Bureau and the City should begin as soon as possible a dialogue with the PPA and the PPCOA to remove the 48-hour rule restriction on interviewing involved officers in shootings and in-custody deaths.

Recommendation 9: The Bureau should implement protocols so that a narrow public safety statement is obtained as a matter of course in officer-involved shootings.

Consistently High Quality of Detective's Investigations

While we have noted gradual improvement of Bureau investigative and review practices, we have observed consistently high quality of performance on some aspects of PPB investigations. Chronologically, the first case of those reviewed here is the shooting of Mr. Perez in 2004; the last is the shooting of Mr. Collins in 2010. In those cases and the other cases we reviewed from that six year period, we saw consistently high performance in the effective canvassing and identification of witnesses to the events. A swift response, deployment of adequate resources, and a clear understanding of the importance of this task led to admirable results.

There were other aspects of the Bureau's investigative processes that displayed more uneven results. For example, in the Perez and Campbell shootings, we saw effective use of crime scene diagrams to develop a visual way to portray the incident which allows a reviewer to better understand the dynamics. However, the use of crime scene diagrams was relatively ineffective in the Gwerder case. One particular area of concern was noted in the Gwerder, Spoor, and Campbell cases, namely, the failure to consistently have witnesses use crime scene diagrams to document their positioning.

Recommendation 10: The Bureau should continue to brief and train its investigators on the importance of developing crime scene diagrams, and most importantly, to use them when interviewing witnesses, have the witnesses document their positions, and ensure inclusion of that documentation in the investigative file.

East County Major Crimes Task Force

The Bureau still uses the East County Major Crimes Task Force for investigative assistance on all officer-involved shootings that occur east of the Willamette River. PARC reports have expressed concern about the effectiveness of using officers from other police agencies to conduct interviews in officer-involved shooting investigations. Those officers are not familiar with Bureau policies, training, and investigative protocols and are therefore ill-equipped to address the specialized nature of an officer-involved shooting investigation. In our review, we found examples of ineffectual investigative techniques by non-Bureau detectives. For example, in the Perez shooting, East County investigators seemed to be reading from a script not carefully adapted to the witness that was being interviewed. Additionally, some of the interviews in the Perez shooting conducted by non-Bureau investigators revealed the use of leading questions, which should be avoided in officer-involved shooting investigations.

While the Perez shooting predated the 2006 PARC recommendations, we also identified issues with the use of East County Major Crimes Task Force in the Campbell shooting which occurred well after the PARC reports. While the use of the Task Force was not as extensive or problematic in that case, we did observe examples where non-Bureau investigators' lack of familiarity with the incident location resulted in less than optimal results.

Recommendation 11: The Bureau should reconsider the 2006 PARC recommendation with regard to the deployment and use of the East County Major Crimes Task Force for officer-involved shootings and in-custody death investigations.

Quality and Timeliness of Internal Affairs Investigations

The evolution in the quality of the PPB's IA investigations into officer-involved shootings between 2004 (Perez) and 2010 (Campbell and Collins) is remarkable. For example, in Goins, the IA "investigation" consisted entirely of the re-packaging of the Detectives' investigation.[9] By contrast, in Campbell, IA investigators interviewed all of the involved and witness officers, along with a large number of civilian witnesses, and prepared a professional summary of the case. While we question investigators' decisions in that case to interview the

[9] This trend is not an unbroken line and is likely, to a degree, investigator driven. For example, the Internal Affairs investigation in Perez, the very first case in our chronology of cases, was relatively thorough.

civilian witnesses via telephone and wonder about the redundancy of some of these interviews, given that the witnesses had been interviewed by Detectives and, in some cases, testified to the grand jury, we applaud the Bureau's commitment to a thorough IA investigation.

These developments follow the recommendations PARC made in its 2006 and 2009 reports. There, PARC recommended that PPB require IA to interview all officers involved in deadly force incidents, along with key civilian and officer witnesses, unless the Detectives' investigation has covered all relevant policy, training, and tactical issues. Bureau executives' commitment to implementing these recommendations was evident in the Spoor case. IA investigators initially interviewed only the two shooter officers. When the case reached the Assistant Chief's office, however, he recognized that the two involved sergeants played critical roles in the planning, tactical communications, and post-shooting response aspects of the incident and sent the case back to IA with instructions to interview these sergeants. It is now IA's general practice to interview all involved and witness officers, as well as all pertinent civilian witnesses. The Bureau should continue this commendable practice, but whenever practicable, should commit to conducting in-person interviews of all relevant witnesses rather than relying on telephonic interviews.

The quality of interviews has improved along with the thoroughness of IA's witness lists. We noted in the Campbell investigation in particular that investigators made obvious and notable efforts to avoid leading questions and demonstrated a willingness to ask hard questions. We will continue to evaluate and comment on the quality of IA investigations as we examine the remaining 11 cases in our review.

When we reviewed the 2006 in-custody death of Mr. Chasse in 2010, we noted significant delays in the IA investigation. While there were unique circumstances behind those delays, it was in part attributed to an Internal Affairs Division understaffed as a result of a Bureau-wide staffing shortage. PPB addressed this problem in 2007 by hiring retired law enforcement investigators to fill IA positions. In our Chasse report, we commended the Bureau for this decision to insulate IA from the vagaries of future staffing crises.

Based on the investigative timelines associated with the more recent cases we reviewed, the civilian-staffed IA continues to produce timely investigative reports. In the seven cases we reviewed, the longest IA investigation (Spoor in 2008) took a total of 10 months, owing in part to the fact the Assistant Chief had

to return the case for additional interviews. The Gwerder investigation (2005) spanned nine and one-half months. The two most recent shootings we reviewed – Campbell and Collins – were completed in five and three months, respectively, both commendable timeframes.

Delays in the Review Process

While some of the seven IA investigations were marked by delays, the real slow down in the process was in the length of time between the completion of the IA investigations and the preparation of the Commanders' findings, and again before the Use of Force Review Boards convened to consider the cases. For example, in Gwerder, the Commander's memo was not signed until seven months after the completion of the IA investigation. In Collins, the Commander waited three months for the Training Division to complete its analysis, and then took an additional five months to complete his review. The shortest – Campbell – was an anomaly, in that it was completed in two weeks.

Additional delays occurred in the scheduling of cases for the Use of Force Review Board. From the time the Commander's memo was complete, the Spoor case was not set for Review Board presentation for another three and one-half months. The remainder of the cases took one to two months to be set for the Review Board. We will be better positioned to comment on trends in the timeliness of the investigative and review processes after we have reviewed all 18 incidents on our slate of cases. It does appear from this limited review, however, that at least beginning in 2010, IA has been working hard to complete cases quickly. While we generally are impressed with the thoroughness of the Commanders' review of shooting incidents, the Bureau has room for improvement in the speed with which its Commanders and Review Board consider critical incidents.

Recommendation 12: Without sacrificing the quality of the review, the Bureau should commit to enforcing firm deadlines for Commanders to complete their findings and for cases to be heard by the Police Review Board.

Quality of Training Division Reviews and Consideration of Tactical Alternatives

Throughout the period under consideration in our review – 2004 to 2011 – the Portland Police Bureau has incorporated Training Division Reviews into its post-incident response to officer-involved shootings. We find this practice

commendable. These analyses, produced by members of the Training Division, are detailed breakdowns of the tactical elements of a critical incident, including decision-making by the first responding units, placement of officers, communications with dispatch and among officers, choice of weapons, and responses to the suspect's actions. They are generally thoughtful and candid. The Bureau's willingness to bring the logic of its subject matter experts to bear in writing on complex and highly charged incidents is also quite rare in our experience with police agencies. We have, moreover, observed the Training Division Reviews evolve over the six years spanned by the incidents we discuss in this report from analyses that were unsigned and provided comparably cursory treatment of the issues to more robust and critical analyses of tactical decision-making and the decision to use deadly force.

The Training analysis of the James Perez shooting in 2004 exhibits a central shortcoming that we saw in several of the other analyses – the failure to consider officer misperception and alternative tactical scenarios. In this incident, officers who pulled over a suspect vehicle may have misinterpreted the hand movements of the driver. One of the officers fatally shot the driver, thinking he was about to pull out a handgun. The Training analysis did not consider the possible other interpretations of Mr. Perez's hand movements as he took his hand out of his pocket or to consider the role of misperception of what Mr. Perez was doing with his hand when he was not pulling out the weapon that he did not in fact have. Moreover, the Training analysis did not sufficiently address the incident from the time when the officers first made contact and began to grapple with Mr. Perez, and did not discuss the different tactical options available at that time.

Similarly, in the Lesley Stewart shooting in 2007, a rifle officer who had been watching from a surveillance position as Mr. Stewart moved about his apartment, fired her weapon when he reached up to a closet shelf, thinking he was about to retrieve a gun. This misperception – there was no gun there – was also skipped over by the Training Division Review in favor of inferences about the shooter's sense of vulnerability in her imperfect cover and her speculations about Mr. Stewart's next moves.

If the implicit reason for avoiding the misinterpretation issue in these and other scenarios is Training's reluctance to second guess an officer's split-second decisions in the field, this misses a clear opportunity. Threat perception is a central pillar of police training. Like many agencies, PPB uses "shoot/don't shoot" exercises and scenarios in many areas of their field training. The premise

of this training is that threat perception is improvable and amenable to training. To decline to delve into the possible reasons why an officer mistook one action for another is to turn away from this subject matter when its examination is most vital.

Other Training Division Reviews appeared to neglect or consciously avoid certain other issues: In the 2005 Gwerder shooting, a SERT sniper made the decision to shoot at a man with a gun before he could walk back into his house from his back yard. Mr. Gwerder had moved about his patio pointing his gun and possibly looking for police positions before turning to re-enter the house. The shooter officer explicitly attributed his decision to shoot to his desire to prevent the suspect from gaining a better position in the house from which he might shoot at the officers or otherwise pose a threat in the near future to the officer and his partners. This officer's decision to take preventative action squarely evokes the thorniest questions at the boundary of the justifiable use of force.[10] While the grand jury had already determined that the shooting was legally justifiable, the question remained for the Bureau to determine whether it was a tactically appropriate interpretation of the PPB's deadly force doctrine. The Training analysis simply does not grapple with what is arguably the central question raised by the incident: whether it was reasonable for the officer to conclude that Mr. Gwerder posed a significant, immediate threat and whether shooting the AR-15 rifle was the only viable way to counter that threat.

In the Collins shooting of 2010, an officer expected to make contact with an intoxicated homeless man with whom he was familiar, and instead was confronted by a bloodied man who walked ceaselessly toward him with a razor cutter. The Training analysis did indeed focus on an alternative scenario, surmising (as did the officer himself), that had the officer been fully informed of the previous threatening actions of Mr. Collins, he would have been better prepared to avoid deadly force. This opens the door to a discussion of how conditions might have been changed, but it focuses on the shortcomings of civilian witnesses over which the Bureau has little control. Instead, the Training analyst could have brought

[10] The dominant police doctrine that sets the boundaries on police use of deadly force in a preventative mode is embodied by the U.S. Supreme Court decision in *Tennessee v. Garner*, 471 U.S. 1 (1985). This decision authorizes the use of deadly force against a fleeing felony suspect if the force is necessary to prevent escape and the officer has probable cause to believe that the suspect poses a significant threat of death or serious injury to himself or others. PPB's use of force policy further clarifies that the threat posed by the suspect must be significant and immediate. [PPB Manual of Policies and Procedures 1010.10.]

constructive hindsight to the decisions that the officer made under extreme pressure about where to move and how to minimize danger to others given the constricted geography of the location.

We are encouraged to observe that the Training Division Review in Campbell, one of the most recent incidents considered in this report, takes an unflinching look at tactical options and alternative scenarios and faces squarely the central question of whether the shooter officer's decision to use deadly force was based on a reasonable calculation of the level of risk posed by Mr. Campbell.

As detailed above, the Training Division Reviews following critical incidents have sometimes exhibited a marked reluctance to examine the fundamental question of when to use deadly force and whether alternative tactical choices might have avoided deadly force. Nevertheless, the Training analyses we have reviewed have shown a general trend toward a more comprehensive treatment of the issues and confident use of the subject matter expertise of the Bureau. It is also important to note that most of the Training analyses have not hesitated to turn a critical eye toward the role and performance of supervisors in the field.

The Training Division Review is a valuable tool in the Bureau's internal evaluation of critical incidents. The Bureau should continue to develop this tool to shine a self-critical light on both the actions of the officers involved in a shooting and the Bureau that trained them.

Tactical Communications Problems

Communication problems are endemic in police work. Viewed in the broadest sense, each one of the incidents we reviewed exhibited particular, often unpredictable challenges to keeping all officers informed of critical information at the scene. Some incidents, however show the dire consequences that can follow if participants are not fully aware of the source or sources of the problem.

The officer who shot Mr. Gwerder in 2005 was candid and articulate about his state of mind just before pulling the trigger. When he heard a single shot fired while he was securing his position, he was unsure who had fired or from what direction. When he saw Mr. Gwerder appear to aim at locations in the back yard, he was not sure whether any SERT or uniformed officers were located in the direction Gwerder was pointing his gun. He was not sure if the suspect could harm the neighbors in the adjacent apartment or take them hostage. In short, he was working from a factual deficit that could have been alleviated by his fellow

officers positioned elsewhere if he or they had focused more on communication and had better tools with which to do it. The accumulation of discrete communications failures – e.g., the liaison officer's lack of familiarity with the wireless infrared communication system; the shooter officer's failure to determine exactly where fellow perimeter officers were positioned; the incompatible radio frequencies between SERT and precinct officers; the incident commander's failure to stay abreast of the negotiations or to recognize the breakdown in communications with SERT – provide a relevant but unsatisfying explanation for why a SERT sniper would decide to shoot an armed suspect who is talking to a Bureau HNT negotiator while walking away from him. The central role of communications breakdowns was recognized at length at the time by Bureau experts. They observed that "communications issues…led to critical decisions being made without all available information." However, based on subsequent cases we reviewed for this report, the Bureau continues to be stymied at times by communications breakdown issues.

By the time of the 2007 shooting of Mr. Stewart, the Bureau had instructed AR-15 operators to wear a radio earpiece in order to ensure they remained current with tactical operations and developing information. This procedure was, in part a response to the Gwerder shooting and had been recommended by PARC as well. The officer who shot at Mr. Stewart did not have her earpiece in but stated, nonetheless, that she had heard the update that the possible hostages were out of the house. The more significant communication breakdown in that incident was the AR-15 operator's failure to communicate to her nearby partners that she felt their position of cover was extremely vulnerable to the suspect should he obtain a gun and that she would have to use deadly force to defend their position if necessary. Had she mentioned this to her partners or the incident commander, they might have taken action to alter their vulnerable position.

In the 2008 incident resulting in the death of Mr. Spoor, confusion reigned in the seconds leading up to the rounds fired at the suspect by officers. Cover officers were urgently called to the scene but no one was assigned to coordinate them or provide them with any information about the threat. While there had been a relatively slow build-up to this moment, with time for discussion and strategizing among the officers present, the sudden emergence of a suspect with a gun was not anticipated and left little time for communication or coordination. A sergeant at the scene did attempt to limit the number of responding officers and instruct incoming units to shut off their sirens but there was insufficient time for this to take effect.

In contrast, the Campbell shooting in 2010 appeared to start as a model of planning and coordination. Yet it ended as an unfortunate culmination of many of the communications problems we have seen in other cases. Important updates about the suspect's state of mind were not broadcast. The incident commanders did not update the custody team about communications with the suspect. The suspect's compliant actions such as exiting the residence were misinterpreted as defiant actions by those uninformed of the police demands with which he was complying. Some officers were aware of the plans to release a canine or use a beanbag shotgun; others were not. Ultimately, the utter lack of communication between the two sergeants at the scene created a potentially unstable condition which may have contributed to what the Bureau ultimately decided was an unnecessary and inappropriate shooting. That the Bureau recognized this and affirmed its concern about tactical communications at a critical incident scene is emphasized by the discipline imposed on the two sergeants following the Use of Force Review Board. Discipline, however is at best an uncertain driver of systemic reform.

One lesson from the Campbell shooting – that a long delay in getting medical attention to a downed suspect is inexcusable – led to substantive changes in equipment, training, and procedure. It would also be prudent for the Bureau to continue to focus on the lessons about tactical communications to be learned from this incident. The Bureau has updated its Critical Incident Management training for sergeants to include a focus on tactical communications. It should also emphasize these lessons in its training for patrol officers to maximize the likelihood this corrective action will have a measurable impact on future critical incidents.

Recommendation 13: The Bureau should consider ways in which it can integrate its Critical Incident Management training curriculum into training opportunities for patrol officers.

Post-Shooting Rescue of Downed Suspects

The Campbell case motivated the Bureau to finally address the issue raised repeatedly by PARC regarding the speed with which medical aid is rendered to downed suspects. It took officers 35 minutes to get aid to Mr. Goins, and 38 minutes to reach Mr. Campbell. Within one month of the Campbell shooting, all sergeants' cars were equipped with ballistic shields, and within three months, all officers had received four hours of in-service training in the use of this tool to safely approach injured suspects who may be armed. This is a positive

development, but it is fair to question why this incident sparked change when so many prior ones did not. Following the Spoor shooting, in which officers reached the wounded Mr. Spoor within 15 minutes by taking what some considered to be an unnecessarily high level of risk, the Use of Force Review Board recommended that the Bureau consider the use of ballistic shields in supervisors' vehicles. PARC repeatedly expressed concerns about delays between an officer-involved shooting and the rendering of medical aid to the downed suspect, and recommended the Bureau modify its policy and training to emphasize the need to render aid more quickly.

Police Review Board

Following a 2010 ordinance amendment, the body formerly referred to as the Use of Force Review Board is now called the Police Review Board. The new ordinance changes the makeup of the Board that convenes to review use of force cases to include an IPR representative as a voting member, two peer officers, and two citizens chosen from a pool of volunteers selected by the Auditor. An Assistant Chief chaired the previous Board, while a civilian facilitator runs the new Board. There was no written record of the prior Board's proceedings; the new Board is required to make public reports of its findings in use of force cases.

The most recent incident reviewed here – Collins – was the first officer-involved shooting to be reviewed under the new ordinance. We had the opportunity to attend one Review Board hearing last fall and were generally impressed with the scope of the review, the thoroughness with which the Board members discussed the numerous issues presented, and the thoughtfulness and professionalism demonstrated by all participants. We will have better evidence upon which to comment on the Board's effectiveness in subsequent reports, when we evaluate additional shootings reviewed by the newly comprised Board.

Role of IPR in Ensuring Robust Investigations and Review

Our review of these seven shootings over a six year period shows much evolution and improvement in the way officer-involved shootings are investigated and reviewed. IPR likewise has evolved, from having minimal involvement in these processes to being a major player. As we note in our review of the Perez shooting, IPR had virtually no role to play in shaping the investigation and participating in the review of the incident. Over the six year period of shootings that is the subject of our current review, IPR played an increasingly important role in both of those processes. The increased quality that we observed in the

Bureau's investigations and review is clearly attributable to more robust protocols, including increasing the authority of IPR to become involved and invested in these processes. The greater and more meaningful involvement of an outside set of eyes and ears has resulted in more thorough and fair investigations and more insightful and meaningful review.

SECTION THREE Recommendations

1 PPB should maintain its partnership with Project Respond and make the Mobile Crisis Unit a permanent team, ideally with expanded personnel, hours, and scope. The Bureau also should continue to employ the CIT program to set high standards for its officers, and should continually work to identify ways to integrate that training into patrol tactics and other standard training curricula. In addition, the Bureau should recognize this new training focus in its evaluation of shooting and force incidents and hold its officers accountable to these high standards.

2 PPB should reexamine its current policy on Taser use in light of current research indicating the elevated dangers of prolonged Taser use.

3 PPB should ensure adherence to its newly-adopted written protocols requiring that all officers who are tactically involved in events leading up to the shooting be identified as potential subjects.

4 PPB should establish a policy that Training Division will be expected to evaluate the tactics and decision-making of every unit in the Bureau, including SERT and CNT, so as to avoid the ambiguities and delay following critical incidents. A written policy would enshrine what we are told is now common practice.

5 PPB should consider whether its protocols on the use of Cadets and their roles during ride-alongs need to be reassessed.

6 PPB should consider developing protocols for how Cadets are to be interviewed in future critical incidents.

7 Except where prevented by documented hardship, IA investigators should maintain the practice of conducting in-person interviews of all relevant witnesses.

8 The Bureau and the City should begin as soon as possible a dialogue with the PPA and the PPCOA to remove the 48-hour rule restriction on interviewing involved officers in shootings and in-custody deaths.

9 PPB should implement protocols so that a narrow public safety statement is obtained as a matter of course in officer-involved shootings.

10 PPB should continue to brief and train its investigators on the importance of developing crime scene diagrams, and most importantly, to use them when interviewing witnesses, have the witnesses document their positions, and ensure inclusion of that documentation in the investigative file.

11 PPB should consider implementing the 2006 PARC recommendation with regard to the deployment and use of the East County Major Crimes Task Force for officer-involved shootings and in-custody death investigations.

12 Without sacrificing the quality of the review, the Bureau should commit to enforcing firm deadlines for Commanders to complete their findings and for cases to be heard by the Police Review Board.

13 PPB should consider ways in which it can integrate its Critical Incident Management training curriculum into training opportunities for patrol officers.

Responses to the Report