Report to the City of Portland on Portland Police Bureau Officer-Involved Shootings and In Custody Deaths

Second Report ◦ July 2013

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ENSURING OPEN AND ACCOUNTABLE GOVERNMENT

CITY OF PORTLAND

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To: Mayor Charlie Hales
Commissioner Nick Fish
Commissioner Amanda Fritz
Commissioner Steve Novick
Commissioner Dan Saltzman

From: City Auditor LaVonne Griffin-Valade

Re: OIR Group – Review of six officer-involved shootings and one in-custody death

In the attached report, the OIR Group presents the results of their review of the closed investigations pertaining to the in-custody death of Timothy Grant in March 2006 and these six officer-involved shootings: Marcello Vaida – October 2005; Dennis Young – January 2006; Scott Suran – August 2006; David Hughes – November 2006; Osmar Lovaina-Bermudez – August 2009; and Keaton Otis – May 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 qualified outside experts to review closed Police Bureau investigations of officer-involved shootings and in-custody deaths. Over the years, the City Auditor has contracted with two outside organizations to examine such events: PARC (four reports between 2003 and 2009) and the OIR Group (2010 report on the in-custody death of James Chasse and the 2012 report on seven officer-involved shootings).

For the attached review, the OIR Group primarily looked at tactical decision making by Police Bureau members that may have led to the use of deadly force. The report contains thirty-one recommendations for improvements in protocols, guidelines, training and other areas of concern. The introduction indicates that a number of recommendations emerged from a single shooting incident, and notes that although the Bureau has made progress since that incident, additional improvements are needed.

I appreciate the thorough analysis and the clarity in presentation of information throughout the report. The team from the OIR Group is made up of highly skilled, knowledgeable professionals, and their review has significant value for my office, for the Independent Police Review division in my office, for City Council, for the Police Bureau, and most importantly, for the community we serve.

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Foreword

"Man killed by police unarmed."

"Man dies after being shot in the face with a Taser."

"Crowd gathers to protest officer-involved shooting."

"Something went terribly, terribly wrong in police shooting."

The use of deadly force by police virtually guarantees a media headline, public attention to the incident, and a spectrum of reactions and responses from the community. Some members of the community will be ardent supporters of their police and will excuse virtually any use of deadly force where the officer provides a colorable explanation. At the other end of the spectrum, some community members will readily make allegations of malicious intent, brutality, and conspiracy and consider any explanation that attempts to justify the police conduct a "whitewash." Police and City executives and legislators must listen to both ends of the spectrum and acknowledge all voices in between.

Cynicism about a law enforcement agency's explanations following a use of deadly force by an officer often stems from an historic lack of objective oversight over these critical incidents. Up until the end of last century, officer-involved shootings were virtually always investigated only by the agency itself, and these investigations received almost no substantive review or critical examination. Virtually no officer-involved shootings or in custody deaths were subject to a substantive critique either internally or by external entities.

That dynamic has changed over the past 30 years, particularly in progressive cities and police agencies. Now, most large cities in America have some type of external oversight with varying degrees of scrutiny, authority, and effectiveness. For the past four years, the federal government has played a greater role in assessing deadly force by local law enforcement, increasingly conducting federal investigations into officer-involved shootings, and moving for judicial oversight in cases that indicate that local internal or external mechanisms have failed to sufficiently check the use of deadly force.

Portland certainly has been at the forefront of this move toward increased attention to officer-involved shootings. In 2001, the City of Portland created an external oversight mechanism that, over the years, has grown in authority and scope. There has been a tremendous increase in transparency for the Portland community regarding Police Bureau shootings, with records from investigations and grand jury proceedings made available to all who are interested. The advent of oversight and greater transparency has served to increase the public's interest in incidents where officers have used the awesome authority granted them to use deadly force on another individual. And most recently, the U.S. Department of Justice has found the Portland Police Bureau (PPB) constitutionally deficient in several areas of policing, including the use and review of force.

It is within this milieu that we offer our Second Report. The report covers seven critical incidents that occurred between 2005 and 2010 and is intended to provide additional insight into these events by examining the objectivity of the Bureau's own investigations and reviews. As we noted in our previous report, the PPB's ability to use a critical incident as a springboard toward systemic reforms has evolved over time. Its current use of exacting Training Division Analyses and a Police Review Board that includes peer officers and members of the public signify the Bureau's willingness to be self-critical in an effort to learn from its mistakes. The Bureau also has an admirable history of opening itself to outside review and accepting recommendations from independent sources that sets it apart from many agencies. These internal review processes, however, must be accompanied by efforts to make substantive modifications in the ways officers act and make decisions in the field. Otherwise, review efforts remain hollow and invisible to the community.

Much of our attention to the seven incidents we review here focuses on tactical decision making by officers that may have led to the use of deadly force. In each case, we look to see whether questionable tactics may have contributed directly or

indirectly to the officers' believed need to use deadly force. As we have observed in many situations handled by other police agencies, reckless tactics, poor supervision, and neglect of basic officer safety principles generally lead to more police shootings than do good tactics, effective planning, thoughtful supervision and adherence to tactical principles designed to keep officers safe.

In short, if officers use tactics consistent with officer safety, they are less likely to get injured or hurt during the course of their duties. They are also less likely to place or find themselves in a situation where they are so vulnerable and feel so threatened that they perceive the need to use deadly force, and the frequency of officer-involved shootings decreases.

To ensure that PPB officers use sound tactics, the Bureau must inculcate tactical principles through clear policy, effective training, and a willingness to hold officers accountable when their performance is inconsistent with Bureau expectations. While the Bureau has made significant progress on this front, this report offers additional recommendations to tighten and develop policies so that officers clearly understand the expectations of its leadership team.

A number of recommendations stem from one shooting we reviewed for this report involving a lieutenant who the City found to have performed so far below the Bureau's expectations that his employment was terminated. The officer appealed the decision to an arbitrator and he was ordered returned to work. Unfortunately, the Bureau did not use this decision as a learning opportunity and did not consider or change any practices as a result of the arbitration decision. This report notes a number of reforms that could have come out of an exacting review and urges the Bureau to consider them now.

Any time an officer uses deadly force resulting in serious injury or death, even if the shooting was found to be "legal," it has tragic consequences for family members of the person shot, can be emotionally wrenching for the involved officers, and can erode public confidence in the police. It is incumbent upon police leadership to train and teach officers how to perform their work safely and then insist that they adhere to that training. Some members of the public will never accept shootings by police officers as legitimate. Nevertheless, the Bureau must strive to learn every possible constructive lesson from each shooting and to turn those lessons into reform, with the ultimate goal of reducing to a minimum the number of these shootings.

Scope of Review

The City of Portland 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. In a report published in June, 2012 ("First Report"), we reviewed seven of the 17 officer-involved shootings. In this report, we examine another six shootings and one in custody death.

Because PARC's review was limited to those cases for which no litigation was pending or still possible, many of the cases on our list to review happened years ago. As a result, some of the training and equipment issues presented in those early cases have been addressed by the Bureau and are no longer relevant. Nonetheless, as we said in our First Report, 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.

In our First Report, we examined six officer-involved shootings in which the subjects who were shot all appeared to be in some significant mental health or emotional crisis, as well as one shooting from 2004 for which outside review was long overdue. We selected the six officer-involved shootings reviewed in this report – incidents involving Marcello Vaida, Dennis Young, Scott Suran, David Hughes, Osmar Lovaina-Bermudez, and Keaton Otis – because they all involved some type of pursuit – either on foot or by vehicle – or standoff with an individual in a vehicle. The in custody death of Timothy Grant followed a struggle with Mr. Grant, who moments earlier had been reported screaming and running into traffic.

For this report, as we did for the prior one, we reviewed all of the PPB's investigative materials for each of the seven critical incidents, including the Detectives' and Internal Affairs (IA) investigations, as well as grand jury transcripts in the one case where those were available (Otis) and arbitration records in the one case in which the discipline of a PPB officer was heard and overturned (Young). We also read and considered the Training Division Analysis and materials documenting the Bureau's internal review and decision-making

process connected with each incident. We requested, received, and reviewed training materials relevant to Tasers, foot pursuits, and vehicle pursuit and intervention techniques. We visited the Bureau's new training academy; spoke with trainers about the curricula taught relating to foot pursuits, shooting at vehicles, and Taser use; and observed Taser training scenarios. In addition, we referred back to training materials we reviewed for our prior report. We met with PPB executives and leaders in the Detectives, Internal Affairs, and Training Divisions. We also attended the Police Review Board proceedings in the Otis case as well as another incident that may be subject to later review. 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.

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

SECTION ONE

Officer Involved Shootings

Summary and Analysis

October 12, 2005 ◦ Marcello Vaida

On October 12, 2005, Officers Chad Gradwahl and Ryan Derry were assigned to the Gang Enforcement Team. Both officers were in uniform patrolling in an unmarked police car. Officer Derry was driving.

At approximately 10:40 pm, the officers attempted to contact Mr. Vaida after they observed him throw an object at a moving vehicle and determined to stop him for offensive littering. Mr. Vaida was on foot. As Officer Gradwahl stepped out of the police car he told Mr. Vaida that he wished to speak with him. Mr. Vaida turned away, reached toward his waistband and ran. Officer Gradwahl chased Mr. Vaida, yelling at Mr. Vaida to stop. Mr. Vaida stopped with his back to Officer Gradwahl. As Officer Gradwahl came to a stop, Mr. Vaida turned to face the officer and raised his hands. When Mr. Vaida raised his hands his sweatshirt lifted slightly at which time Officer Gradwahl observed an object in Mr. Vaida's waistband that appeared to be the butt of a gun. Officer Gradwahl also noticed that Mr. Vaida had a "shooters glove" on the right hand and no glove on the left hand.

Officer Gradwahl drew his firearm and commanded Mr. Vaida to go to the ground. Mr. Vaida did not comply but began looking around. Meanwhile, Officer Derry had driven the police car to where Officer Gradwahl and Mr. Vaida had stopped. When Officer Derry arrived, Officer Gradwahl directed Officer Derry to use his Taser on Mr. Vaida. Officer Derry fired his Taser at Mr. Vaida as Mr. Vaida turned. The Taser had no apparent effect and Mr. Vaida resumed running away from the officers. Reviewers later opined that Mr. Vaida's heavy jacket impeded the effectiveness of the Taser.

Officer Gradwahl resumed his foot pursuit, with Officer Derry following several feet behind. As Mr. Vaida continued to run, Officer Gradwahl observed him looking back at the officers while Mr. Vaida's hand remained at his waistband area. Officer Derry broadcast over his radio that the officers were in foot pursuit. The foot pursuit continued into an apartment complex parking lot. Mr. Vaida rounded a parked car, causing Officer Gradwahl to lose sight of him momentarily. As Officer Gradwahl continued to pursue by coming around the back of a parked vehicle, he then observed Mr. Vaida shoot at him. Officer Gradwahl was between ten and fifteen feet from Mr. Vaida when the shooting commenced. Officer Gradwahl then returned fire and began to move toward the cover of a parked car. Once behind the parked car, Officer Gradwahl continued to shoot until he observed Mr. Vaida fall to the ground. During the exchange of gunfire, Officer Gradwahl performed a tactical reload of his weapon. Mr. Vaida got up from the ground, at which time Officer Gradwahl fired additional rounds until Mr. Vaida went down again.

As Officer Derry trailed the pursuit, he lost sight of Officer Gradwahl for 1-2 seconds and then heard gunfire. Officer Derry said that "it was obvious to me, there's no question that the subject has almost ambushed Gradwahl as he turned the corner and has opened gunfire on him." Officer Derry said Officer Gradwahl was out of his sight but saw the muzzle flash of a gun firing toward where he had last seen Officer Gradwahl. Officer Derry drew his weapon while taking cover at the corner of a building and fired at Mr. Vaida until he observed him fall to the ground.

When the shooting ended, both officers observed Mr. Vaida throw his handgun away. Officer Gradwahl estimated that the gun landed approximately ten feet from Mr. Vaida. Mr. Vaida continued to move around and ignore the officers' commands to lay still. At one point, Mr. Vaida retrieved a cell phone from his jacket and made a call.

The two officers used their radios to direct responding officers to the location and ordered bystanders out of the immediate area. When cover units arrived, Officers Gradwahl and Derry were relieved from their positions and escorted away. Arriving cover officers evacuated bystanders and established a perimeter around the scene. Officers armed with AR15 rifles were designated to cover Mr. Vaida. Mr. Vaida continued to ignore repeated commands to be still.

A responding officer was ordered to use less lethal rounds to shoot out a streetlight that was seen as providing Mr. Vaida a silhouette of the responding officers. In addition, that officer fired several less lethal beanbag rounds at Mr. Vaida as he lay on the ground at which point Mr. Vaida complied with orders to remain still. The Bureau's Special Emergency Response Team (SERT) was activated and eventually took Mr. Vaida into custody. Mr. Vaida survived his wounds.

The Commander's Review Memorandum found that the use of force by the officers was in policy and recommended a debriefing for Officers Gradwahl and Derry.

The Use of Force Review Board met on December 6, 2006 and found that the use of deadly force by Officer Gradwahl and the use of deadly force and use of the Taser by Officer Derry were within policy. There were no further recommendations emanating from the Review Board.

Timeline of Investigation and Review

10/12/2005	Date of Incident
1/18/06	IA investigation began
3/22/2006	IA Investigation completed
10/9/2006	Commander's Findings completed
12/6/2006	Use of Force Review Board

Analysis/Issues Presented

Insufficient Radio Communication

When Officers Gradwahl and Derry decided to stop Mr. Vaida, they did not radio their intent to do so or provide the location of their stop. Similarly, when the officers first went in foot pursuit, neither officer radioed the initiation of that pursuit nor broadcast any information during the pursuit. It was only after the Taser was used and toward the end of the second foot pursuit that Officer Derry radioed that they were in foot pursuit, but he provided no further information about location, description of the suspect, or any belief about whether the suspect was armed. Almost contemporaneous with that radio broadcast, shots were fired and another thirty-five seconds elapsed before Officer Derry provided a location for backup units to respond.

As the Bureau recognized in developing its 2005-06 in-service training, encounters with individuals in the field can be very hazardous because the officer may not know who the person is, if they have any weapons, or what their intent is. Academy training instructed officers to attempt to broadcast before arrival or upon arrival if possible and to provide basic information such as the number of suspects, reason for the contact, sex, race, and age of the suspect, and the location of the stop. With regard to foot pursuits, the 2005-06 PPB in-service training provided that:

> *When tactically feasible, officer(s) should broadcast information about the changing dynamics of the foot pursuit, information such as:*
>
> - *Direction of travel*
> - *Subject description*
> - *Any changes in circumstance*
> - *Subject behavior*

In this incident, the responding officers did not radio any information as they arrived to encounter Mr. Vaida, even though there was no apparent inability to do so. Moreover, during the first foot pursuit, there was no broadcast by the officers or any information provided about whom they were chasing. When Officer Derry finally radioed that they were in foot pursuit after the Taser incident and during the second chase, he provided no information about the location or the suspect. As a result, it was not until the shooting ended that the two officers provided any information to other PPB officers about location or the nature of the operation.

The training analysis prepared after the investigation of this incident expressly recognized the tactical shortcomings of the responding officers and their failure to provide stop location at the onset of a stop or pursuit.

Initial Foot Pursuit

When Officer Gradwahl stepped from his car, he saw Mr. Vaida reach toward his waistband then run into a parking lot. Officer Gradwahl gave chase. During the first part of the pursuit, Officer Gradwahl maintained visual contact with Mr. Vaida. When Mr. Vaida stopped, Officer Gradwahl stopped as well about 15-20 feet away and, when he observed a possible firearm on Mr. Vaida's person, he drew his weapon and gave commands to Mr. Vaida. The training analysis found that these actions from Officer Gradwahl were consistent with PPB training.

One tactical decision that was not discussed by the training analysis was the apparent joint decision of the officers to have Officer Gradwahl go into a foot pursuit while Officer Derry followed along in the police car. The interviews of the officers similarly did not focus on this tactic and did not expressly ask Officer Derry whether he lost sight of the suspect and his partner as he drove his police car. While there is some advantage to having a police car's assets close at hand, progressive police tactics show that it is generally outweighed by the dangers of the tactic in that partners are split and what results is a single person pursuit. However, the potential officer safety issues presented by this tactic were not identified or evaluated by the training analysis or any subsequent PPB review.

A final tactical decision that was not discussed in the training analysis is the decision by Officer Derry not to activate emergency lights when he pursued Mr. Vaida and his partner. Certainly, the activation of those lights might be expected during this operation, yet the training analysis is silent as to this issue.

Use of the Taser

Officer Gradwahl stated that when Officer Derry arrived, he recalled telling Officer Derry that Mr. Vaida may have a gun and instructed him to "tase him." Officer Derry said that he did not hear Officer Gradwahl's statement about the gun, but had observed Mr. Vaida refusing commands and the direction from his partner to "tase" Mr. Vaida. Officer Derry stated that he then warned Mr. Vaida that he would be tased and fired the Taser. Both officers observed the Taser probes strike Mr. Vaida in the back, but Mr. Vaida seemed to be unaffected by the activation and then ran through the apartment complex.

The training analysis opined that the officers' decision to maintain distance, maintain lethal cover, give commands, and use the Taser was consistent with training. However, the evidence was unclear that the officers maintained lethal cover prior to deployment of the Taser. Moreover, the training analysis does not discuss the advisability of the use of the Taser on an apparently armed suspect. Finally, the training analysis does not discuss the importance of Officer Gradwahl ensuring that his partner knew of his observation that Mr. Vaida was armed prior to instructing him to deploy the Taser.

The training analysis suggests that it may not have been the best option for Officer Derry to warn Mr. Vaida that he was about to deploy the Taser on him. The analysis suggests that such a warning may have provided Mr. Vaida an opportunity to react, and that in dynamic and potentially dangerous encounters, the need to immediately use force may justifiably supersede a warning. However, the training analysis fails to recognize that Officer Gradwahl had verbally instructed Officer Derry to use the Taser, clearly within earshot of Mr. Vaida. As a result, Mr. Vaida was already on sufficient notice to react to the deployment of the Taser. Accordingly, it appears that the warnings given by Officer Derry would not have provided Mr. Vaida any tactical advantage but rather offered him another opportunity to obey the officers' instructions.

The training analysis recommends that Taser training should intersperse repetition and scenario practice where no warning would be appropriate. Training and policy should not, however, intentionally diverge from one another. Training should be as consistent with policy as possible. Even the Bureau's new Taser policy does not provide much guidance on when warnings might not be appropriate.[1] Accordingly, should PPB determine that certain instances exist when no "Taser" warning is appropriate, its policy should acknowledge and define these circumstances.

The use of the Taser in this case had no apparent effect on Mr. Vaida. The training analysis opined that this was due to Mr. Vaida's clothing or a movement away from the probes. However, the analysis does not recommend additional briefing or training on the ineffectiveness of Taser use under these circumstances. In our view, this omission was a missed opportunity to use this incident as a leaning experience, both for the involved officers and for the entire Bureau.

[1] "Members must give a warning prior to using an ECW [Electronic Control Weapon] if feasible."

Final Foot Pursuit

After the Taser proved ineffective, Mr. Vaida again ran from the officers, and Officer Gradwahl resumed the chase with Officer Derry 5-10 feet behind him. During the pursuit, Officer Gradwahl estimated that he was 15-20 feet behind Mr. Vaida. Officer Gradwahl continued the pursuit with his weapon unholstered. During the chase, Officer Gradwahl observed that Mr. Vaida's right arm was fixed at his waistband while his left arm was pumping in a running motion. Officer Gradwahl also observed Mr. Vaida repeatedly looking back at him during the pursuit.

The training analysis had a number of concerns with Officer Gradwahl's tactics during this final foot pursuit. First, the training analysis noted that if officers believe a subject is armed, they should implement a "tactical apprehension" or some other plan. In discussing preference for a tactical apprehension – for instance, following at a distance while waiting for additional resources for apprehension – the training analysis noted that pursuing an armed subject places the officers at a tactical disadvantage and will greatly increase risk factors, and that PPB officers should increase their following distance of an armed subject. The training analysis also noted that PPB officers should attempt to maintain visual contact, without the intent to apprehend while waiting for additional resources, consider setting up a perimeter, seek cover, and request other assets such as K9 and SERT.

The training analysis noted that Officer Gradwahl's pursuing distance of 15-20 feet would not have allowed him much time to react should Mr. Vaida commence an attack, which in fact he did eventually do. The training analysis concluded that the officers' safest option would have been to create and maintain more distance and radio for backup units to begin to set up a perimeter.

The training analysis also noted that officers should avoid engaging in a foot pursuit with their weapons unholstered because of the dangers that an officer might stumble and fall and lose control of his or her weapon at a critical moment, that the officer could quickly become involved in a physical struggle with an unholstered weapon, and that it increases the possibility of an accidental discharge. However, rather than critique the officer for this technique, the training analysis apparently accepted Officer Gradwahl's explanation that he wanted his firearm in his hand should Mr. Vaida pull a gun on him. While a pursuing officer could always use this explanation, in this case, it again belies the

unwise choice Officer Gradwahl made in pursuing an armed suspect the way he did.

The training analysis noted that pursuing officers should be aware of the hand and arm movements of the suspect and whether the suspect is looking back or targeting the officer. The training analysis concluded that Mr. Vaida had displayed a number of behaviors consistent with an armed fleeing person. The analysis concluded that the safest option would have been to create distance and seek tactical apprehension, yet Officer Gradwahl actually closed the distance during the pursuit. The analysis noted that as a result, Officer Gradwahl was very close, without cover, and in motion, when Mr. Vaida began shooting at him.

The Commander's Review Memorandum expressed similar concern about the officers' pursuit of an armed suspect:

> *It is easily conceivable that the rounds that put the officers, especially Gradwahl, in harm's way might have found their mark and the outcome would have been tragic. I am reminded of the Thomas Jeffries shooting in the summer of 1997. In this situation, Officer Jeffries pursued the suspect into a backyard and only briefly lost sight of him. As he came around the corner the suspect fired a round that landed between the ballistic panels on the vest he was wearing. The wound killed Officer Jeffries.*

The Commander indicated that while he found the shooting well within policy, he recommended that the involved officers be debriefed on foot pursuits and that the Training Division develop training around this and other incidents.

One critical fact not discussed in the training analysis is that when Mr. Vaida rounded the car just before he started firing, both officers lost sight of him momentarily. When the officers next saw Mr. Vaida, he had the gun pointed at Officer Gradwahl and began firing. Best practices instruct officers to stop pursuing whenever they lose sight of the suspect and seek cover. In this case, there is no evidence that Officer Gradwahl ever intended to stop pursuing once he lost sight of the suspect.

At the time of the incident, training had been initiated on the inherent dangerousness of foot pursuits and officer safety tactics and principles designed to reduce their danger. But the Bureau did not yet have a directive outlining its expectations on initiation and handling of foot pursuits. In fact, as discussed later

in this report, the Bureau did subsequently develop and implement a directive regarding foot pursuits.

Positioning and Tactical Decision-Making During the Shooting

When Mr. Vaida began firing on Officer Gradwahl, the officer immediately returned fire, using a one-handed grip. Officer Gradwahl then moved away from Mr. Vaida, toward a parked car for cover. As Officer Derry passed between cars, he heard gunfire and saw a muzzle flash. He then saw Mr. Vaida firing a handgun at Officer Gradwahl. Officer Derry drew his weapon and began firing at Mr. Vaida. Officer Derry moved away from Mr. Vaida and positioned himself behind the corner of a building.

After Officer Gradwahl went around the parked car, he took a kneeling position and began using a two-handed grip. Officer Gradwahl used up all of the ammunition in his pistol, performed a reload, and continued to fire at Mr. Vaida. Officer Gradwahl stated that he began to focus on his sights and slow his rate of fire.

Officer Gradwahl said that he was aware of his backdrop and stopped firing at one point until a car passed by, and also stopped firing when Mr. Vaida went down. He stated that when Mr. Vaida attempted to get back up, Officer Gradwahl fired again. Mr. Vaida went down a second time and Officer Gradwahl stopped firing. Officer Gradwahl estimated the distance between him and Mr. Vaida during the initial exchange of gunfire at 10-15 feet and at the end of the sequence at about 30 yards. Officer Gradwahl fired a total of 30 rounds at Mr. Vaida.

Officer Derry said that he fired from an upright stance. He said that his distance from Mr. Vaida was initially 15-20 feet and approximately 30 feet at the end of the firing sequence. Officer Derry said that he initially fired rapidly, attempting to center his front sight on Mr. Vaida. Officer Derry stated that he was concerned that Mr. Vaida was not going down and slowed down his last shots in order to use his sights more carefully. Officer Derry said that he stopped firing when Mr. Vaida went down. Officer Derry said that his backdrop during the shooting was parked cars and shrubbery. Officer Derry fired nine rounds at Mr. Vaida.

Mr. Vaida fired five rounds at Officer Gradwahl before his firearm malfunctioned. Mr. Vaida received multiple gunshot wounds during the exchange but survived the encounter.

The training analysis found that the use of deadly force by the officers was consistent with PPB training. While the training analysis recognized that a two handed grip using sights is the preferred method of firing, the dynamic situation of the officers being fired upon made "instinct" shooting a survival reality. The training analysis concluded that the officers were aware of their backdrop.

In reaching its conclusion, the training analysis assumed certain facts that were not established during the investigation and, as illustrated above, neglected discussing certain facts that were clearly established. For example, the analysis stated that Officer Gradwahl likely had his flashlight in his support hand when he began firing. However, there is no evidence to support this conclusion since Officer Gradwahl did not know whether he had his flashlight in his hand at the time of the shooting. Second, while the training analysis concludes that both officers were aware of their backdrop, a number of rounds struck residential buildings and vehicles. Unfortunately, the investigation did not document which officer or whether Mr. Vaida likely fired the stray rounds, so it is impossible to assess whether the involved officers were as fully aware of their backdrop as they asserted.

The training analysis does not assess the number of rounds fired by the officers and whether the amount was consistent with training. The fact that Officer Gradwahl fired thirty rounds during this encounter should have, in and of itself, raised conservation of ammunition questions and called for exacting analysis. In addition, at one point, Officer Gradwahl's weapon was out of bullets, a circumstance that most training regimens instruct officers to avoid. Moreover, the time it took to tactically reload provided Officer Gradwahl an opportunity to reassess the threat level presented by Mr. Vaida; but there is no evidence to suggest that the officer did so and the training analysis does not identify or assess this issue.

Specialized Officers May Lose Perishable Skills

The training analysis noted that the two involved officers' assignment to the Gang Enforcement Team was largely investigative. Both officers spent the majority of their time in plain clothes, working as part of a larger team, conducting investigations and surveillance. The training analysis noted that some basic uniform patrol skills, which may have once come naturally to them, such as notifying dispatch of their stop and location and immediately broadcasting the foot pursuit, were no longer automatic. The training analysis indicated that the manifold survival skills inherent in uniform patrol tactics are perishable. While

this observation demonstrates a keen insight into how Bureau officers assigned to non-patrol positions could be disadvantaged should they need to perform patrol tactics, the analysis provided no suggestions on how this phenomenon could be addressed on a going-forward basis.

Recommendation 1: The Bureau should review current protocols to determine whether they adequately ensure that officers in specialized units are receiving sufficient training regarding perishable skills necessary to perform patrol functions.

Post Shooting Analysis

After the shooting sequence ended, Officers Gradwahl and Derry observed Mr. Vaida down with his handgun on the ground. The officers commanded him to lay still. Officer Derry radioed that they had been involved in a shooting, provided the location, and requested medical to respond. Officer Gradwahl broadcasted a safe approach route for responding officers. The officers directed bystanders away from the area.

Once responding officers arrived, Officers Gradwahl and Derry were relieved by other officers and escorted from the scene. AR-15 rifle operators were positioned to cover Mr. Vaida. Medical support was staged nearby. Mr. Vaida continued to refuse commands to lay still and no attempt was made to approach him. SERT was activated to take Mr. Vaida into custody.

A responding officer was directed by an on-scene sergeant to use a less lethal shotgun to shoot out an overhead light that he believed was illuminating the positions of the cover officers. The officer indicated that he fired 5-6 rounds at the light before he was successful. At the time, the officer said the pistol was still on the ground, approximately 7-10 feet from Mr. Vaida.

The training analysis concluded that the use of the less lethal shotgun was probably the safest and most expedient tool to disable the light. However, the analysis contains no discussion about whether the light was negatively impacting the tactical response of cover officers, perhaps in part because the investigation did not produce any information critical to such an assessment. Ideally, experts from the Bureau would have traveled to the scene and examined whether the light was an impediment to successful apprehension of Mr. Vaida. As a general principle, it is low light not the existence of light that makes tactical planning more difficult. Second, the less lethal shotgun is not designed to shoot out

streetlights and the reporting officer noted it took a number of rounds before he was able to successfully break the light. The investigation did not attempt to learn how readily the light could have been turned off by contacting the City power company before using the less lethal shotgun in this unorthodox way.

Mr. Vaida continued to reach about himself. The officer who shot out the overhead light warned Mr. Vaida that if he did not stop moving, he would be shot with less lethal munitions. When Mr. Vaida again reached for something, the officer struck Mr. Vaida in the leg with one round of less lethal. Mr. Vaida was observed pulling off his shirt and when he placed his hands out of view, the officer fired three more rounds of less lethal at him, which the officer indicated struck Mr. Vaida in the leg. SERT ultimately used an armored vehicle to approach Mr. Vaida, handcuffed him, and transported him to an ambulance.

The training analysis found that the post-shooting actions of Officers Gradwahl and Derry were consistent with training noting that they continued to use cover, communicated with each other, broadcast their location and situation, directed responding units, and directed bystanders to safety. The training analysis also found the actions taken by the first arriving backup officers and supervisors consistent with training. The backup officers installed cover units with AR-15 rifle operators, relieved Officers Gradwahl and Derry and removed them from the scene, evacuated bystanders, established perimeters and designated a command post.

The training analysis concluded that because of the lack of cooperation displayed by Mr. Vaida and his proximity to the gun, it was appropriate to activate the SERT team for a hazardous, post-shooting approach to a suspect. The training analysis also found that the use of the less lethal shotgun against Mr. Vaida with prior warnings was consistent with training.

As a result of the necessary time lag needed to activate SERT, over an hour elapsed between the time of the shooting and when Mr. Vaida began to receive medical attention, even though such assets were on-scene within a few minutes of the radio request for medical aid. The training analysis does not discuss any alternatives to waiting for SERT or any possible plans for more quickly apprehending Mr. Vaida. While Mr. Vaida was observed to be moving about and retrieving and using his cell phone, none of the actions were described as aggressive, and no officers observed an attempt by Mr. Vaida to rearm himself. Fortunately, Mr. Vaida survived this encounter. A more immediate approach, however, would have provided Mr. Vaida more immediate medical attention and

avoided the perceived need to use non-lethal munitions in an attempt to keep him from moving around.

This incident echoes earlier critiques regarding the apparent slowness in assessing conditions and providing medical attention to individuals downed by an officers' use of deadly force. As we noted in our First Report, PPB, to its credit, has recently responded to those criticisms by outfitting and training its officers to use a ballistic shield in order to approach downed individuals and take them into custody so that paramedics can more readily provide medical assistance.

Quality of Investigation and Review

Lack of Independent Follow Up in the IA Investigation

As we have noted in our earlier report, during this time frame, IA had a practice of not conducting its own interviews but simply relying on the interviews and other information gathered during the criminal investigation. While the detectives' interviews of the involved officers are relatively thorough, there are gaps in information that could have been addressed by subsequent administrative interviews. Additionally, because the detectives' investigation is focused on the question of whether the use of deadly force was legal, administrative interviews are needed to address other tactical issues. For example, the detectives did not question Officer Gradwahl about whether he intended to continue to pursue the suspect after he lost sight of him or whether he intended to stop pursuing. Moreover, the lack of an administrative interview made it difficult to assess the involved officers' understanding of the Bureau's expectations regarding initiation and continuation of foot pursuits. The Bureau has more recently recognized the need to conduct separate Internal Affairs interviews of the involved officers and, following discussions prompted by our First Report, IA revised its written Standard Operating Procedure specifically to require this expanded scope of review.

Delay in the Preparation of the Commander's Review Memorandum

As noted above, it took over six months between the completion of the Internal Affairs investigation and the Commander's Review Memorandum. There is no documented explanation for the time delay in its preparation. As we commented in our First Report, timely completion of the review process is important for

critical incidents. Specifically, we recommended that without sacrificing the quality of the review, the Bureau should commit to enforcing firm deadlines for Commanders to complete their findings

Critical Factual Inaccuracy in Detectives' Report

The Detective's report contains a summary of the interview of Officer Gradwahl that states that at no time did Officer Gradwahl lose sight of the suspect as he continued to flee. Yet our review of the transcript of Officer Gradwahl's interview indicates that he told detectives that he momentarily lost sight of the suspect as he went around a parked car. Because subsequent reviewers often rely upon interview summaries in forming their assessments of a critical incident, it is crucial that such summaries of interviews be completely accurate.

Commander's Review Memorandum Relied on the Factual Inaccuracy In the Detectives' Report

The Commander's Review Memorandum is the assessment by the involved officers' Commander of the officers' tactical decision-making and decisions to use deadly force. In the Commander's Memorandum, the Commander apparently relied in part on the interview summaries to write that the officers never lost sight of the suspect. However, Officer Gradwahl stated that he did momentarily lose sight of the suspect and when he regained a visual, the suspect was firing at him. Moreover, Officer Derry indicated that he lost sight of both the suspect and Officer Gradwahl at the time of the shooting. The reliance on faulty information reflects negatively on the Commander's recommendations.

Potential Witnesses Held for Lengthy Time

The shooting ended in an apartment parking lot close to a bar. Responding officers kept the patrons inside for several hours until they were interviewed. The interviews of some of the patrons did not occur until almost 3:00 am. Several of the patrons expressed unhappiness about their being "detained" for so long. A review of the interview summaries showed the patrons being unhelpful to the investigation, perhaps in part due to the lengthy time during which they were not allowed to leave the bar.

The partial explanation that appears in the reports for holding the patrons for so long was a belief that the scene was still active because there was an ongoing search for a second suspect. While, in fact, there was some confusion about the

existence of a second suspect, the reports do not describe with any specificity whether the patrons could have been escorted to safety rather than being held in the bar for four hours.

The review of the shooting incident does not identify the legal issues that were presented by this possible bar "detention" nor does it provide any recommendations about how to handle such issues in the future. Certainly, potential witnesses should be identified and efforts should be made to gain their cooperation as soon as practicable. Additionally, persons who may be in harm's way because of an active scene should be kept safe. However, without more documentation, explanation, or analysis, the holding of witnesses for a lengthy period of time without giving them the opportunity to leave does present the specter of possible detention without cause. It would have been preferable to identify, discuss and assess this issue during the critical incident review process.

Recommendation 2: The Bureau should consider developing guidelines in its officer-involved shooting protocols to ensure that potential witnesses are not held at the scene for longer than necessary and that any circumstances surrounding a lengthy delay are documented in appropriate reports.

Training Division Review Does Not Cite Its Author

While the training analysis candidly critiques the involved officers' performance in certain respects, the report does not contain the name of its author. As we previously commented in our First Report, it is important to be able to attribute the conclusions of the analysis to the individual or individuals responsible for the review. We understand current practice is for the Training Division Review to name its authors, and encourage the Bureau to continue this practice.

Training Division Review Fails to Compare Involved Officers' Performance to Actual Training

The training analysis noted that the last time PPB presented formalized foot pursuit training had been during the 1997-98 annual in-service. The training analysis further noted that such training had been developed as a result of the fatal shooting of Officer Jeffries during the course of a foot pursuit. The analysis noted that the Vaida shooting incident represented the third time in approximately one year when PPB officers were involved in a shooting subsequent to a foot pursuit. Largely due to an increasing local and national awareness of the dangers of foot

pursuits, the PPB Training Division developed a block of instruction devoted to foot pursuit tactics as part of the 2005-2006 in-service. The training analysis indicated that neither involved officer in the Vaida shooting had attended the in-service training at the time of the shooting, but nevertheless critiqued the event using the tactical standards put forth in the 2005-06 foot pursuit training doctrine.

While applying protocols in place during the time of the review process has some appeal, it does not allow an exacting review of whether the involved officers acted consistently with the training they had actually received before the incident. This is compounded by the lack of an administrative interview of the officers in which they should have been questioned about their understanding of Bureau expectations regarding foot pursuits. Because one of the goals of the critical incident review process is to ensure accountability and discipline when officers do not perform consistently with their training, it is critical that the training analysis outline what the involved officers' training was at the time of that incident. The fact that this training analysis does not do so made the document much less helpful in judging any potential accountability on behalf of the officers. The analysis would have been more useful if it had assessed the officers' performance against the standard of these officers' actual training at the time of the incident. It could have then also considered the officers' performance compared to what was being taught at the 2005-06 in-service.

Recommendation 3: The Bureau should consider refining its Training Division Review protocols to ensure that the analyses include each involved officer's training record and adjudge the officers' performance based on the training provided to them up until the time of the incident.

Identifying Individuals in the Police Reports by Their First Names

Several of the police reports in the investigative files refer to involved individuals by their first names. The nature of an officer-involved shooting demands a certain formality to the preparation of reports that is undercut when the reports refer to individuals solely by their first names.

Recommendation 4: The Bureau should consider modifying its report writing materials to discourage referring to persons by their first names in police reports and to provide a standard method for distinguishing persons with the same surname.

January 4, 2006 ◦ Dennis Young

On January 4, 2006 at 2:17 am, Lieutenant Jeff Kaer contacted the occupant of a vehicle stopped in the middle of the street. Though on duty in Southeast Precinct at the time, Lt. Kaer had responded to the location in Northeast Precinct because his sister called him to report the suspicious car, which was positioned near the sister's home. The residence had been flagged for an immediate response because the sister's son had been shot recently in a road rage incident. In his later interview, Lt. Kaer said that he was not concerned about the car as his sister did not express serious concerns about the car, but he decided to check it out anyway. Lt. Kaer did not notify dispatch or the precinct in which the suspect car had been observed.

Lt. Kaer located the car in question and parked his police car behind it. He radioed for cover and then walked to the driver's door with his flashlight illuminating the interior. Lt. Kaer noticed that the driver – later identified as Dennis Young – appeared to be asleep with a prying implement on his lap. The car was in reverse gear with the engine running and Mr. Young had his foot on the brake pedal. Lt. Kaer said that he noticed the trunk lock, driver's door lock, and the steering column were all broken. Lt. Kaer said that because the car was a "junker," he was not concerned with the broken locks. Lt. Kaer said that because of Mr. Young's position and because he had also seen a beer bottle in the car, he thought he was dealing with an intoxicated driver.

Lt. Kaer tapped on the window with his flashlight, which did not awaken Mr. Young. Lt. Kaer said that the car door was locked but that Mr. Young's window was open about six inches. Lt. Kaer reached in and unlocked Mr. Young's door. He then shined his flashlight inside the car and Mr. Young startled awake. Lt. Kaer instructed Mr. Young to put the car in park three times. After receiving no response from Mr. Young, he placed his right palm against Mr. Young's face and pushed him across the seat. Lt. Kaer then reached into the vehicle and shifted the car into park.

Lt. Kaer then grabbed Mr. Young's left arm, placed him in a control hold, and told Mr. Young to put his other hand on the back of his head. Because Mr. Young still had his seat belt on, Lt. Kaer began to work the shoulder harness over the suspect's arm while he maintained the control hold.

At about this time, Lt. Kaer realized that the cover officer had arrived. Lt. Kaer instructed Mr. Young to turn the car off. When Mr. Young responded that he

could not turn the car off because there were no keys, Lt. Kaer asked whether the car was stolen. According to Lt. Kaer, Mr. Young's eyes widened as he started looking around, leaned into the car more, and pulled Lt. Kaer's arms into the car. Mr. Young grabbed the gearshift lever, shifted the car into gear and pulled forward. The door frame of the car struck Lt. Kaer's arm as it lurched forward, spinning him around about a quarter turn.

The cover officer arrived from the opposite direction as had Lt. Kaer and parked his car a few feet in front of] the suspect vehicle. He had been on routine patrol when he received the request to cover the call. Despite utilizing his in car computer in an attempt to learn more, the cover officer said he did not know who he was covering or what the nature of the call was, but did not believe it was an urgent call because there was no tone of urgency in the requestor's voice when he asked for cover.

Because there was no information about the nature of the problem that the cover officer was responding to, he had no idea what direction from which to respond. The cover officer said that when he turned onto the street, he saw Lt. Kaer standing outside the driver's door of the suspect vehicle. The cover officer thought that Lt. Kaer may have needed help but was not sure because he was staring into the headlights and spotlight of Lt. Kaer's vehicle. The cover officer got out, jogged over to the suspect vehicle and took a position to the left of and slightly behind Lt. Kaer. He heard Lt. Kaer giving Mr. Young instructions. Lt. Kaer did not communicate with him regarding the nature of the problem.

According to Lt. Kaer, after the car struck him and spun him partially around, the car screeched, continued to move forward and in a diagonal direction, traveling a short distance, screeched its tires, and struck a tree on the sidewalk. Lt. Kaer had drawn his handgun and yelled several times at the driver to stop the car. Mr. Young put the car in reverse and accelerated backwards toward Lt. Kaer. Lt. Kaer sidestepped to his left, out of the path of the car, and fired two rounds at Mr. Young, striking him once. The car came to an initial stop and then slowly rolled forward before finally stopping at the curb line. Lt. Kaer said that he fired at Mr. Young out of fear of being hit by the car. He said that he did not think he had anywhere to go and was stuck in the middle of the street.

The cover officer said that after the car lunged forward, he stepped back and the car ran into a tree placed along the sidewalk. The cover officer saw Mr. Young lurch forward in his seat. The cover officer then retreated to the other side of the street, drew his handgun, and ordered the driver to stop. The cover officer

observed the car suddenly accelerate backwards and he heard two "pops" that sounded like gunfire. At this point in time, the cover officer estimated that he was 15-20 feet to Lt. Kaer's left and that Lt. Kaer was about five feet from the suspect vehicle when he fired.

The cover officer said that he approached the car and fired his Taser at Mr. Young to prevent him from driving away again. The Taser darts struck Mr. Young. The cover officer then reached in and put the vehicle in park. Lt. Kaer and the cover officer pulled Mr. Young out of the car. Lt. Kaer broadcast that there was an officer-involved shooting and requested medical assistance. The cover officer ran to his car for a CPR mask but could not locate one. Lt. Kaer went to his car but similarly was unable to locate a CPR mask. The cover officer finally located a mask from a responding officer and he and Lt. Kaer began performing CPR. Paramedics had access to Mr. Young immediately upon their arrival. Mr. Young was pronounced dead at the scene.

Review and Disciplinary Process

Training Division Review

The training analysis in this case was comprehensive and critical of Lt. Kaer's tactical decision-making. The review concluded that Lt. Kaer made decisions that were inconsistent with the Training Division's "philosophies." First, the training analysis faulted Lt. Kaer for not taking advantage of time and waiting for cover to arrive, running the license plate to learn if the car was stolen, and checking the inside of the car more thoroughly. The analysis further found problems with Lt. Kaer not notifying dispatch or the precinct that he was responding to the call and giving limited information when requesting cover, causing the cover officer to approach from a less tactically desirable direction. The analysis noted that the two officers failed to communicate throughout the incident, a possible cause of the divergent responses to the car when it lurched away from Lt. Kaer.

The Training Division Review opined that Lt. Kaer was "tunnel visioned" on the car and may not have obtained a good view of the area around the car. As a result, Lt. Kaer ceded the opportunity to locate potential positions of cover and concealment and identify escape routes if tactical retreat became necessary. In addition, the analysis noted that Lt. Kaer failed to identify himself as an officer when he contacted the driver of the car. The analysis concluded that Mr. Young may not have known that Lt. Kaer was an officer because Mr. Young was asleep or passed out when Lt. Kaer first contacted him, the emergency lights of Lt.

Kaer's car were not visible to Mr. Young, and Lt. Kaer's headlights and spotlight probably flooded Mr. Young's vehicle from the rear, potentially blinding him.

The training analysis also examined the cover officer's use of the Taser and concluded it was consistent with the PPB policy at the time. The policy authorized Taser use to overcome physical resistance, which included attempts to flee such as Mr. Young's driving away.

While the training analysis noted that the request for and provision of medical assistance was timely, it also criticized both on-scene officers for a lack of familiarity with their equipment, as neither officer was able to locate a CPR mask in his car.

Finally, the review recommended that the Training Division should:

- Continue to develop scenarios that emphasize tactical advantages;
- Develop discussions and exercises that expose officers to an analysis of the pros and cons of shooting at moving vehicles;
- Explore methods of conditioning officers to recognize the threat of moving vehicles and condition them to go to cover;
- And research trends in law enforcement about how best to deal with moving vehicles.

Commander's Review Memorandum

The commander reviewed Lt. Kaer's actions and found that the shooting was not a violation of Bureau policy and was within the policy of PPB's directive involving shooting at moving vehicles because there were no other reasonable means available at the time to avert or eliminate the threat posed by Mr. Young's operation of the car. The commander's conclusions were at apparent odds with the Training Analysis' criticism of Lt. Kaer's tactical decision making.

Assistant Chief Memorandum

Assistant Chief Lynae Berg handwrote a subsequent notation indicating that she concurred with the Commander's finding that Lt. Kaer's use of deadly force was within policy but controverted the Commander's findings as to Lt. Kaer's performance and found that his actions and decisions were not consistent with PPB training.

Use of Force Review Board

The Use of Force Review Board concluded that Lt. Kaer's use of deadly force was justified. The Board however, sustained unsatisfactory performance allegations relating to a number of decisions that Lt. Kaer made prior to the use of deadly force. The Board also concluded that Lt. Kaer violated the Bureau's shooting at moving vehicle directive and that Lt. Kaer's actions were precipitating factors in the use of deadly force. Voting members of the Review Board recommended various levels of discipline from two weeks without pay to a demotion, with the consensus being a four-week suspension. Chief of Police Rosie Sizer accepted the Board's consensus recommendation and referred the case to the Mayor with a recommended four-week suspension.

Mayor's Decision

The Police Commissioner – a position then held by the Mayor – is the final decision-maker in disciplinary matters involving PPB members. In this case, Mayor Tom Potter (who had been the Chief of the Police Bureau fourteen years earlier) determined that Lt. Kaer's performance warranted termination from the Bureau. In the pre-disciplinary letter to Lt. Kaer, the Mayor wrote that Kaer's decision to use deadly force was not at issue but that he was being terminated because of his poor judgment and decision-making leading up to the decision to use deadly force. The letter of proposed termination and Internal Affairs materials were released to the media before either Lt. Kaer or the Union president had seen the letter. Lt. Kaer and his representative met with the Mayor for a due process meeting, after which the Mayor issued his final decision to terminate Lt. Kaer on August 16, 2007.

Arbitrator's Decision

Pursuant to the current post-discipline process, the Portland Police Commanding Officers Association filed a grievance on Lt. Kaer's behalf, alleging that Lt. Kaer's termination was without just cause. When the dispute was not resolved at lower levels of the grievance procedure, the union, on behalf of Lt. Kaer, advanced the case to arbitration.

In addition to challenging the finding that Lt. Kaer's decision-making and performance violated Bureau policy, the union also alleged that the City had violated the Collective Bargaining Agreement ("CBA") which required that discipline be handled in a way that was least likely to embarrass the commanding

officer before other employees or the public. Specifically, the union alleged that the Mayor's failure to notify the Lieutenant of his intent to terminate prior to releasing this information to the media violated this provision of the CBA.

During the arbitration, the union advanced a number of specific challenges to the disciplinary action including the following:

- The primary reason that Lt. Kaer was disciplined was not his conduct but the result of his actions, namely a fatal officer-involved shooting.
- The charge of poor performance was too vague to provide useful guidance to employees.
- Training principles and techniques were never intended to be rules of conduct.
- No Portland Police officer had ever been disciplined for tactics leading up to a critical incident.
- The termination sanction violated the principles of progressive discipline.
- Lt. Kaer was placed back to work after the incident and had performed well during the sixteen intervening months until he was placed on suspension.

The arbitrator agreed with many of the union's arguments and found that the City failed to prove by clear and convincing evidence that it had just cause for terminating Lt. Kaer.

The arbitrator noted that the Mayor had agreed that Lt. Kaer's use of deadly force was justified because he reasonably believed that there was an immediate threat of death or serious physical injury. The arbitrator concluded that it was untenable for the City to fault Lt. Kaer for not trying to get out of the way of a vehicle that was rapidly approaching him.

The arbitrator also relied on the Commander's Memorandum, which had concluded that Lt. Kaer's actions did not violate PPB policy. In that document, the Commander noted that the actions of the suspect often dictate the actions of the officer. The arbitrator used the Commander's comment to then find: "In the judgment of this arbitrator, Dennis Young wrote the script that resulted in his death." The arbitrator concluded that when Mr. Young made the choice to put the car in gear, he set in force a new set of circumstances independent of any prior conduct by Lt. Kaer and found that Young's attempt to escape from the scene in order to avoid arrest by setting his vehicle in motion must be evaluated as a separate sequence of events.

Once he uncoupled the decision-making of Lt. Kaer prior to the shooting from the shooting itself, the arbitrator agreed that Lt. Kaer's decision-making prior to the time the car was set in motion was inconsistent with PPB policies, training, and practices and therefore sustained the City as to that charge.

The arbitrator nonetheless concluded that discharge was inappropriate in this case because:

- The City failed to prove that the shooting at moving vehicles policy was violated.
- The facts that served as the basis for unsatisfactory performance did not rise to the level of conduct that demanded immediate discharge.
- Lt. Kaer had no previous discipline.
- Lt. Kaer worked for sixteen months after the incident while performing his duties capably.
- The training on the new policy regarding shooting at moving vehicles was incomplete.
- The Mayor's belief that Lt. Kaer did not have the ability to serve as a member of the Bureau was not shared by any of the command staff that reviewed the case.
- The City violated the Collective Bargaining Agreement by the premature release of the proposed termination letter.

The arbitrator then reduced the discipline to a thirty day suspension. As a result, the City was required to pay Lt. Kaer almost a whole year of back pay for the time in which the grievance and arbitration proceedings were pending.

Timeline of Investigation and Review

1/4/2006	Date of Incident
1/19/2006	Grand Jury Proceedings
3/21/2006	IA investigation began
7/21/2006	IA Investigation completed
10/2/2006	Supplemental IA Investigation completed
1/25/2007	Commander's Findings completed
2/28/2007	Use of Force Review Board
5/7/2007	Mayor's Pre-Disciplinary Decision
8/16/2007	Mayor's Final Disciplinary Decision
6/5/2008	Arbitrator's Decision

Analysis/Issues Presented

PPB's Review of Issues Raised by the Arbitrator

Following a critical incident such as an officer-involved shooting, the involved agency should conduct an exacting review to identify potential accountability, training, policy, supervision, and equipment issues. Examining the incident through multiple lenses generally reveals lessons about the shooting. It is then incumbent upon the police agency to export those lessons back to its members to minimize the likelihood of similar problems reoccurring.

In this case, the Bureau conducted an exacting review of the shooting and the numerous tactical issues surrounding it. In contrast the subsequent arbitration proceedings also raised a plethora of issues, but there is no evidence that the Bureau studied those issues with an eye towards learning and reform.

Recommendation 5: The Bureau should develop a procedure ensuring that an after-action report is created following arbitration findings to determine whether those findings call for systemic reform.

Specifically in this case, the Bureau failed to focus on the following nine arbitration findings and issues that it could have used in an effort to improve its policies and practices:

- *The Arbitrator's finding that the Collective Bargaining Agreement requiring that command officers not be subjected to unnecessary embarrassment was violated.*

One justification for reducing the discipline in this case was the arbitrator's finding that the City violated the Collective Bargaining Agreement by releasing to the media the Mayor's letter of intent to terminate Lt. Kaer. While the City's lawyers contested the allegation during the administrative proceedings, there is no evidence that PPB or the City considered systemic reform to the notification process on a going forward basis. Besides its obligation to comply with the Collective Bargaining Agreement, principles of fairness and respect demand development of protocols to ensure that the employee learns of any decision to discipline before the public has access to this information.

Recommendation 6: The City and the Bureau should consider devising written protocols to ensure that employees are notified of any intent to discipline them prior to notifying the general public.

- *Allegation that Lt. Kaer's termination was unfair because it was based not on the policy violation but on the consequences of his actions – a fatal officer-involved shooting.*

At arbitration, the union argued that it was only because a person died as a result of Lt. Kaer's use of deadly force that he was being disciplined for poor tactical choices. The Bureau could have used this case to open a discussion of the degree to which consequences matter for purposes of administrative accountability.

In the American system of criminal justice developed from common law, the same act, such as shooting at an individual, will incur different punishment depending on whether the victim is struck and if so, lives or dies. Borrowing from that common law tradition, legislatures enacted criminal provisions in which the consequences of the action often have a great impact on the penalty suffered by the actor. For example, the consequences are increasingly greater for an impaired driver if he or she is involved in a traffic collision, or if as a result of that collision a person is injured or dies.

In our view, the analogy to criminal law is valid and there should be no legal impediment to increasing discipline in the administrative police law arena when consequences to others rise. A policy statement to that effect included in the Bureau's disciplinary guidelines would provide better guidance to officers, supervisors, and executive staff and remove future arguments in arbitration proceedings. Such a statement would also assist in ensuring consistency of discipline among similarly situated officers.

Recommendation 7: The Bureau should consider developing a written policy statement informing its members that the consequence of any violation of Bureau policy is a potential aggravating factor to be considered in determining the level of discipline to be imposed.

- *Disciplining officers for unsatisfactory performance.*

As noted above, at the arbitration hearing, the union raised issues regarding PPB's current unsatisfactory performance directive, arguing that it is too vague to provide guidance to its employees. The union also argued that training principles were never intended to be rules of conduct subject to disciplinary sanctions and that no PPB officer had ever been disciplined for tactical decision making.

Progressive police agencies recognize that officer decision making that is inconsistent with training and principles of officer safety can lead to situations in which an officer feels constrained to use deadly force, and that officers who perform consistently with their training are less likely to find themselves in such situations. Police departments have also recognized that when tactical decision making falls far below expectations and training, there is a need for accountability, including formal discipline. However, the arguments raised by the police union at the arbitration hearing had some purchase here because PPB policy does not expressly and specifically alert its officers in its unsatisfactory performance directive that they may be disciplined for poor tactics or actions inconsistent with training. Even after the arguments raised by the union in this case, there is still no express language in PPB policy that alerts officers to this potential. In addition, the lack of express and specific language fails to inculcate these principles among PPB's leadership.

Recommendation 8: The Bureau should consider revising its directive specifically informing its members that substandard performance and tactics can be a basis for imposing discipline.

- *Progressive discipline issues.*

PPB policy currently recognizes that one important purpose of discipline is to remediate officers who transgress policy and to provide increasingly greater sanctions for those who continue to choose not to perform consistently with the Bureau's expectations. PPB policy also notes that certain transgressions of policy are so serious that principles of progressive discipline are not to apply and potential remediation of the officer is not a viable option. However, while the use of excessive force and other serious offenses are expressly listed as violations which are not necessarily subject to principles of progressive discipline, the policy fails to include poor tactical decision making or performance that leads to a critical incident as an example of conduct potentially exempt from progressive discipline principles. While current policy wisely recognizes that the list of policy violations that might not be candidates for progressive discipline is not intended to be exclusive, the express inclusion of poor tactical decision making as another example would provide further guidance to its members and make a termination decision more readily defensible.

Recommendation 9: The Bureau should revise its directives to expressly state that unsatisfactory performance issues in critical incidents may be significant enough to warrant severe levels of discipline without the usual prerequisite of previous progressive discipline.

- *Lieutenant Kaer's return to work as a field supervisor following the shooting.*

During much of the pendency of the internal investigation and internal review process that ultimately led to a decision to discharge Lt. Kaer, he had been returned to duty and apparently performed his assigned tasks competently. This fact was used by the union and accepted by the arbitrator as a reason to find that termination was not necessary in this case. The attorneys representing the Bureau were hard-pressed to argue that Lt. Kaer was no longer able to perform his roles as a Bureau field lieutenant as a result of this incident, when in fact he had been performing that role without apparent problems for sixteen months after the incident.

Current Bureau policies allow for an employee to be relieved of duty or administratively transferred during the pendency of an investigation. In this case, Lt. Kaer was apparently returned to duty because the Bureau did not contemplate at the time that his actions in the officer-involved shooting would lead to a

decision to terminate him. If Lt. Kaer had been relieved of duty or transferred to an administrative assignment, the City would not have had to address the issue of the Lieutenant's competent performance at arbitration. More importantly, if the City or Bureau had sufficient concerns about Lt. Kaer's performance in the field as a result of this case, he should have been removed from that assignment to avoid exposing the public and the Bureau to the risks of another tactically deficient critical incident. The Bureau provided us with a draft policy that precisely addresses this issue (Post Officer Involved Deadly Force Temporary Altered Duty Process). We recommend it be implemented as quickly as possible.

Recommendation 10: The Bureau should implement its current draft policy setting forth the circumstances under which an officer may be relieved of duty or administratively transferred during the pendency of a critical incident investigation, including when the Chief has a reasonable basis to believe that the officer may be terminated.

- *Weaknesses in the Bureau's shooting at vehicles policy.*

The arbitrator found that tactical deficiencies that Lt. Kaer made when approaching the vehicle could not be considered a violation of the Bureau's shooting at moving vehicles policy because the vehicle was not yet moving at that point. The arbitrator further found that it was not appropriate to fault Lt. Kaer for not trying to get out of the way of a rapidly approaching vehicle.

In our view, the arbitrator adopted a wooden and overly narrow interpretation of the Bureau's shooting at moving vehicles policy. Even though Lt. Kaer shot at the driver of a moving vehicle, the arbitrator seemed to find the policy inapplicable since some of Lt. Kaer's decisions and behavior occurred while the vehicle was stationary.

Unfortunately, there was no apparent internal discussion following the arbitrator's decision regarding ways to strengthen the policy to provide better guidance about the Bureau's expectations and to prevent future arbitrators from reading the policy so narrowly. Certainly, the "shooting at moving vehicles" policy was also intended to provide guidance to officers regarding how to approach or deal with stationary vehicles that are a gear shift movement away from being mobile. Thus, a simple renaming of the policy to "approaching and shooting at occupied vehicles" would eliminate any confusion as to whether the policy was intended to address only vehicles that are already in motion or also intended to address tactically unwise approaches to vehicles that could readily be set in motion.

Moreover, a minor modification of current language that covers vehicles that are stationary but easily able to be placed into motion would also ensure that scenarios such as that encountered here would be covered by the policy. While the analysis of the arbitrator in the Young case can be seen as a too narrow and faulty interpretation of existing policy, on a going forward basis, the Bureau has the ability to reshape the policy so that future arbitrators could not so readily reach a finding inconsistent with the intent of the policy.

Recommendation 11: The Bureau should consider revising its shooting at moving vehicles policy to instruct its members that the policy is intended to cover a wider array of circumstances including the approach to stationary occupied vehicles that are likely to be put into motion.

- *Implications for discipline when an arbitrator overturns one of several sustained allegations.*

As noted above, the arbitrator failed to sustain the Bureau with regard to its findings on the shooting at moving vehicles allegation, but did sustain the Bureau with regard to the performance issues relating to Lt. Kaer's actions prior to the shooting. However, in part because he sustained only one of the allegations, the arbitrator reduced the discipline from termination to thirty days.

The shooting at moving vehicles charge and the performance issues were closely related and there is overlap between the two allegations. It was not clear whether the Police Commissioner believed that either allegation supported the discharge decision or whether it was the combination of two violations that resulted in the termination finding. If it had been clear at the outset that, in the City's view, either charge supported termination, the arbitrator may not have reduced the discipline based on his conclusion that only one of the allegations had been proven.

Recommendation 12: In termination cases involving multiple allegations, the Bureau should articulate which allegations, if any, individually supports its termination decision.

- *Belief expressed by Commander that the actions of the suspect "dictated" the officer's response.*

The PPB Commander's Memorandum, in recommending that there was no violation of policy, opined that sometimes actions taken by officers are dictated

by the actions of the suspect. Lt. Kaer's representatives argued at arbitration that his dedication to the mission of PPB should "not be discarded because the actions of a drug-addled criminal forced him to use deadly force." The arbitrator embraced these sentiments and concluded it was Mr. Young that "wrote the script that led to his demise."

The notion that the suspect is the one that dictates officer actions in a critical incident goes against the orientation of modern day tactical precepts. The focus on tactics designed to safely take suspects into custody is intended to not allow the suspect to dictate the actions. A confident well-trained officer who uses tactical advantages he or she possesses will be more likely to dictate the outcome, rather than the suspect.

To place the onus of any outcome on the suspect provides an excuse for the outcome and does not sufficiently credit well-trained officers and their ability to bring suspects into custody intelligently and safely. Officers do have the advantage of communication, numbers, and equipment and if employing tactics effectively, can use these advantages to ensure a preferable result.

It is our understanding that patrol tactics training emphasizes the importance of officers maintaining control of a situation and not allowing the suspect to dictate outcomes. The Bureau could have used the results of Lt. Kaer's arbitration to prompt discussion by the Bureau on this issue, particularly as to whether its command staff should continue to officially express the view that officer-involved shootings are dictated by the suspect's actions.

Recommendation 13: The Bureau should ensure that command staff recognizes that it should be the overarching objective of every tactical engagement for the Bureau to dictate the outcome.

- *Ensuring that final decision makers findings are not undercut at Arbitration by earlier determinations in the decision making process.*

As noted above, the decisions on outcomes of this case ranged from a finding by Lt. Kaer's commander that he had violated no policies to a finding by the Police Commissioner that termination was the appropriate level of discipline. The fact that the Bureau command staff did not share the Police Commissioner's view was part of the rationale the arbitrator used to upend the discharge decision.

When a critical incident is subject to different levels of review, it presents the potential that the disciplinary decision will be revised as it moves up those levels. One way to lessen the impact of seeming disagreement at the lower level about disciplinary outcomes is to adopt the analytical framework that exists in our legal system. Under that hierarchy, a court's decision is good law unless reversed by a higher level appellate court, in which case the lower decision is of no import.

The Use of the Taser

The Training Analysis found that the use of the Taser was appropriate because policy at that time suggested that fleeing was included in the category of physical resistance allowing use of the Taser. Using that logic, the Training Analysis found that the officer who used the Taser could have thought that the suspect was still trying to get away when he deployed the weapon. The problem with this analysis, which was apparently accepted by the Review Board, is that the officer did not articulate this justification when he was interviewed. Instead, the officer indicated that after the shooting, he did not want to reach into the car, so he deployed the Taser and then reached in to put the car into park. The officer also indicated that he did not issue any commands or warnings prior to deployment of the Taser, even though policy at that time instructed officers to do so.

The fact that the training analysis and subsequent review process apparently assumed a rationale for why the officer used the Taser that was not articulated by the officer himself is troubling. The fact that there was no consideration of whether the officer could and should have issued commands or warnings to Mr. Young when he deployed the Taser was also not addressed during the review of the shooting incident.

More recently, the Bureau's policies regarding Taser use have come under scrutiny and criticism. In the September 2012 U.S. Department of Justice findings letter, the DOJ expressed concerns about the policy authorizing Taser use when a person solely displays the intent to engage in physical resistance. The letter further notes that Bureau policy defined physical resistance as actions that prevent or attempt to prevent an officer's control of a subject, but do not involve attempts to harm the officer. The use of the Taser in the Young shooting is another example of PPB-sanctioned Taser use that parallels the concerns raised by DOJ in its findings regarding PPB's use of this weapon. There was no evidence or articulation by the officer who used the Taser that Mr. Young was attempting to harm the officers at the time the Taser was deployed.

The recent Settlement Agreement between the City of Portland and the DOJ requires the Bureau to tighten its Taser policy, including provisions regarding the permissible use of the Taser that would address and rectify the issues elucidated in the Young shooting. The Bureau has proposed a revised policy that incorporates these concerns.

Efforts to Conceal Mr. Young's Body

After Mr. Young had been pulled from the car and pronounced dead at the scene, a responding sergeant requested paramedics to place a sheet on him prior to the scene being photographed. While this request was well intentioned as an effort to prevent Mr. Young's body being viewed by civilian bystanders, the placement of the sheet disturbed the positioning of Mr. Young's body. One police report described Mr. Young's arm being folded to his side so that the sheet could completely cover his body. Another police report indicated that because a sheet was placed over Mr. Young measurements of the crime scene could not be taken until the Medical Examiner arrived to remove the sheet.

Many agencies use evidence screens to prevent onlookers from viewing an expired person's body without compromising the crime scene. We have seen these screens used following other, more recent PPB shooting incidents. The compromising of the crime scene in this incident was identified during the investigation and the curriculum of recent PPB in-service training for all sworn personnel addresses the contamination issue, but it is not clear whether the additional interest of shielding the body of the deceased from onlookers has been made a part of crime scene doctrine as well.

Recommendation 14: The Bureau should ensure that its protocols on the handling of persons who die at the scene of a critical incident avoid contaminating the scene while maintaining the person's dignity by keeping them out of public purview.

Key Issues Not Identified or Addressed During Review Process

As detailed above, the review of the Young shooting as set out in the training analysis did identify a number of tactical deficiencies made by Lt. Kaer in responding to the incident. However, there were several issues that were not identified and discussed:

- *Lieutenant Kaer's Reach Into the Vehicle*

Lt. Kaer reached into the suspect vehicle while it was running and in gear, first to place the vehicle into park and then to attempt to use a control hold to pull Mr. Young from the vehicle. Both efforts proved ineffective. Reaching into a suspect's vehicle, particularly when the engine is running and the vehicle is in gear, is an extremely risky maneuver. A driver who is sitting and seat belted in a car presents a special challenge to physically remove, with an officer outside the vehicle in a disadvantageous position to do so. Of particular concern is the potential that the suspect will overcome any control hold and be able to drive the car away and strike the officer with the vehicle or worse, cause the officer to be dragged and potentially run over by the moving vehicle. However, the tactical issues involving the dangers of reaching into occupied vehicles were not identified in the review of the Young shooting and accordingly, no action plan was devised to address the issue.

While, as we noted in our First Report, after a prior shooting with similar issues (the Kendra James shooting), PPB developed a training block regarding vehicle extractions, the effectiveness of this training must be questioned considering that the James Jahar Perez and Dennis Young shootings involved similar fact patterns with similar poor results.

- *Lieutenant Kaer's Decision to Respond to a Call Initiated by His Sister*

Unless there is an exigency, best police practices discourage on duty police officers from personally responding to calls for service from family members. In this case, Lt. Kaer responded on duty to a request from his sister, even though he was not working in the precinct in which his sister resided. When on duty police officers respond to a call for service from a family member, there is the likelihood that the police officer will either consciously or subconsciously respond in a different way than if it was a call for service from the general public. While it was clear from the investigation that Lt. Kaer was responding out of his area of assignment to a personal call for service from his sister, the potential downside of such a response was not addressed during the review of this shooting incident.

Recommendation 15: The Bureau should provide written guidance to its members that disfavors on duty handling of matters involving family members.

- *Failure of On-Scene Officers to Locate a CPR Mask*

The training analysis noted that neither on-scene officer was able to locate a CPR mask in his vehicle to assist in performing CPR on Mr. Young, yet there was no apparent action plan developed during the review process to address this issue. PPB officers should be aware of where any piece of equipment is in their vehicles. A briefing bulletin reminding officers of the availability of emergency equipment and where it is located in their vehicles should have been prepared and disseminated to the Bureau as a whole. In addition, the Bureau could have considered the initiation of more regular inspections of police vehicles so that officers have better awareness of the equipment available to them to perform job duties.

Recommendation 16: The Bureau should provide periodic briefings to field personnel regarding the placement of emergency equipment in patrol vehicles.

Delays in Investigation and Review

As we have found in a number of cases reviewed in our First Report and elsewhere in this report, there were significant delays in the investigative and review process. In this case, it took six months to complete the Internal Affairs investigation and another two and a half months to complete a supplemental investigation. More concerning, it took nearly three months before the Commander's Review Memorandum was completed.

March 20, 2006 ◦ Timothy Grant

On March 20, 2006, at 3:06 p.m., PPB officers were dispatched to a disturbance call in Northeast Portland. Numerous callers described a male subject who was screaming, running into lanes of traffic and falling down in the street. Officer Paul Park arrived on-scene at 3:10 p.m. and observed the subject, later identified as Timothy Grant, on the ground lying in the eastbound lanes of Sandy Boulevard. A civilian had positioned her car in the eastbound lanes to stop traffic from running into Mr. Grant. Other civilian witnesses were attempting to assist Mr. Grant.

Officer Park approached Mr. Grant, placed his knee on Mr. Grant's shoulder and attempted to handcuff him, but was unable to successfully do so as Mr. Grant struggled with him. Officer Park ordered Grant to stop resisting and to give him his arm. A civilian witness tried to assist Officer Park by grabbing Mr. Grant's legs but Officer Park told the citizen to step back because he did not want the citizen to get hurt. After Officer Park successfully placed one handcuff on Mr. Grant's wrist, Mr. Grant was able to use his handcuffed hand to trap Officer Park's hand on the handcuff. Officer Park then punched Mr. Grant one time in the back to free his hand, then tased Mr. Grant in the back and neck using drive stun mode, but was still not able to complete the handcuffing process. At that point, Officer Park called dispatch to report that he had used the Taser twice on Mr. Grant but that it had had no effect and requested that backup units quicken their response. At the same time, Officer Park called for an emergency medical response.

A backup officer arrived on scene and began to assist Officer Park. That officer grabbed Mr. Grant's right arm and attempted to handcuff him. A second backup officer arrived and restrained Mr. Grant's legs until he was handcuffed. Within a few seconds, by using a second pair of handcuffs, the officers successfully handcuffed Mr. Grant. While awaiting paramedics, the responding officers tried to keep Mr. Grant on his side but were not entirely successful as Mr. Grant continued to roll back and forth.

Medical personnel responded and checked on Mr. Grant, who originally was conscious and breathing, but rambling and incoherent. During the medical evaluation, Mr. Grant stopped breathing and lost consciousness. Mr. Grant's handcuffs were removed and medical personnel attempted to resuscitate Mr. Grant but were not able to do so.

An autopsy by the Medical Examiner determined that while he had scrapes and contusions to his extremities, there were no physical injuries to Mr. Grant that contributed to his death. The Medical Examiner determined the death to be accidental and caused by an overdose of cocaine. The Medical Examiner opined that the use of the Taser did not contribute to the death of Mr. Grant.

The unsigned training analysis[2] noted that when Officer Park arrived to the location, his observations led him to believe that Mr. Grant was a danger to himself and others because of the distinct likelihood that Mr. Grant would get up and again run into traffic. The analysis indicated that Officer Park was forced to make the decision to wait for backup or take immediate action to handcuff Grant while he was on the ground and found no fault with his decision to engage immediately.

The training analysis opined that Officer Park's use of a focused blow on Mr. Grant's lower back to distract him so that he would release the free handcuff was consistent with training and successful. With regard to the use of the Taser in drive stun mode, the analysis noted that deploying the Taser that way can only achieve compliance through the infliction of pain and does not "lock up" muscle groups, which occurs when the Taser darts are used. According to the training analysis, the writer had recently learned that at the time of the incident Officer Park had been newly acquainted with the Taser and that Park thought he would not be able to get enough of a spread with the darts for them to be effective.[3] The training analysis recommended that rather than use the Taser in a pain compliance mode, officers should "dart" the subject and then drive stun in another part of the body to lock up some of the subject's muscle groups in order to gain more physical control over the subject.

The training analysis found that the two backup officers who used a second pair of handcuffs to secure Mr. Grant demonstrated quick thinking to resolve a problem. The analysis found that Park appropriately recognized that there was a

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[2] We commented in our First Report about the fact that during this period, a number of training analyses had no author attribution and spoke to the reasons that attribution of the training analysis is important.

[3] The source of this information about Officer Park's thought processes is unclear, as it does not appear in his interview or elsewhere in the investigative file. We commented in our First Report about the need to ensure that conclusions about tactical decision making of involved personnel should be limited to information contained in the investigative file.

medical emergency when he asked for a medical response relatively early in the sequence. With regard to the efforts of the officers to keep Mr. Grant on his side, the training analysis stated that current research concludes that allowing Mr. Grant to roll onto his stomach would not contribute to his death but because of "public perception" and the fact that it does not harm the subject to keep him on his side, Training Division recommended that efforts should be made to keep subjects on their side.

The training analysis cited a video entitled "Multiple Taser Use and Excited Delirium" that Officer Park had viewed prior to the incident and cited comments made in that video by the then Oregon State Medical Examiner that it was important to gain control of individuals as soon as possible to protect the public, the individual, and the officers. As a result, the training analysis concluded that Officer Park's decision to go hands on with Mr. Grant rather than waiting for cover officers was consistent with training and the recommendations of the Medical Examiner.

The Commander's Memorandum likewise found no reason to second-guess Officer Park's decision to go hands on with Mr. Grant without waiting for cover officers to arrive.

Timeline of Investigation and Review

3/20/06	Date of Incident
10/26/06	IA investigation began
1/19/07	IA Investigation completed
6/12/07	Commander's Findings completed
7/25/07	Use of Force Review Board

Analysis/Issues Presented

Opining on the Importance of Witnesses

In this incident, the Bureau relied on officers from outside agencies working with the East County Major Crimes Task Force to conduct interviews of several civilian witnesses. One non-Bureau member conducted witness interviews and prepared witness summaries in which he stated that certain witnesses were "critical witnesses to the event." Report writing practices teach that when preparing witness summaries, officers should not opine on the importance of various witnesses but that the summaries should simply be a recitation of the facts. Any opinion about the relative importance of witnesses should be left to the prosecutorial authority to which the report is being submitted.

No Substantive Internal Affairs Investigation

In this case, both the Bureau and the Independent Police Review Division (IPR) found that there was no need to conduct a substantive Internal Affairs investigation and for purposes of administrative review, the Detectives' investigation was merely repackaged. However, because the fact gathering was limited to whether the force used on Mr. Grant violated criminal law, the Bureau's reviewers had little information regarding other important issues involving tactics and collateral issues. For example, as noted above, because Officer Park was not asked about his familiarity with the Taser during the initial interview, the training analysis relied on information gained outside of the investigative process and not contained in the file. In addition, as detailed below, the potential delay in providing medical treatment to Mr. Grant was not identified as an issue and not addressed during the administrative review, possibly because it was not a central part of the criminal investigation.

In our view, additional fact gathering during the administrative phase of any critical incident resulting in death is necessary. The criminal investigation is primarily concerned with whether the force used by officers violated criminal law and does not fully flesh out facts involving tactics and other issues necessary for a robust administrative review. For that reason, at a minimum, officers involved in critical incidents must be interviewed during the administrative investigation to ensure the administrative decision makers have sufficient information to undertake a complete analysis of the officers' tactical decisions.

Responding Officer's Decision Not to Wait for Cover Officers

Neither the training analysis nor the Commander's Memorandum examines the facts collected during the investigation in order to sufficiently consider whether it would have been preferable for Officer Park to wait for cover officers to arrive prior to going hands on with Mr. Grant. While Officer Park and the subsequent analysis by his supervisor suggested that he had no choice but to act quickly in order to prevent harm to Mr. Grant and others, the scene described by Officer Park and civilian witnesses does not clearly present this exigency. At the time, Mr. Grant had lain down in the street and a civilian had blocked off the lane in which he was lying. If Mr. Grant continued to remain relatively static in that position, the chance of harm coming to him or others was minimal.

Moreover, the analysis does not consider how the incident eventually unfolded to assess Officer Park's decision making. The time line of the incident showed that Officer Park had an extended period of time in which he was hands on with Mr. Grant, that as a result he felt it necessary to strike him in the back and use the Taser twice on him; yet all of these efforts were still insufficient to successfully secure him. As Officer Park stated during his interview, "I was there by myself. I didn't have any cover officers with me and it was a losing battle." When interviewed, a civilian witness indicated that he thought the officer should have waited for more officers to arrive before engaging Mr. Grant. As a result of Officer Park's decision to immediately engage, there was a four minute period in which Officer Park needed to apply various force options on Mr. Grant, none of which proved successful in getting him into custody. In striking contrast, once cover officers arrived, it only took a matter of seconds with minimal force for Grant to be handcuffed and secured. Neither the training analysis nor the Commander's Memorandum discusses whether it is preferable to have an extended four minute struggle involving applications of various force or a somewhat delayed response in which several officers successfully take a person into custody with less force in mere seconds.

Officer's Failure to Immediately Broadcast His Position

As noted above, Officer Park went hands on, delivered one strike, and used the Taser twice on Mr. Grant before he used the radio to request immediate cover and communicate a request for medical to respond. PPB officers are trained that it is tactically important to broadcast their position when they are about to go hands on with an individual. Officer Park indicated that because there was a bank robbery call occurring at the same time, he did not want to fill the radio waves with his

call. The training analysis did not consider whether this rationale was consistent with optimal officer decision-making or whether it still would have been preferable for Officer Park to use the radio before he went hands on with Mr. Grant.

Officer's Decision to Deploy the Taser in Drive Stun Mode

While the training analysis does address Officer Grant's decision to deploy the Taser in stun drive mode and suggests a likely more effective deployment technique, there is no evidence in the file that such recommendations were ever delivered to Officer Park or the Police Bureau as a whole. When individual and/or systemic issues are detected during a critical incident analysis, it is important to isolate those issues and document what the agency has done in response.

Delayed Response in Providing Medical Attention

When some of the involved officers were interviewed, they indicated that while they were on scene, it seemed that the medical response was taking longer than it should. The Bureau later learned that the medical rescue team had been on scene for some time but had staged nearby, waiting for a go ahead from the responding officers. Once medical personnel learned that it was clear to enter the scene, they immediately responded and began treating Mr. Grant. However, there was evidence that there was a short period of time where rescue was staged nearby and ready to respond and officers failed to communicate to them the fact that the scene was stable.

This potential critical issue was not identified during the administrative review of this incident. Coordination between responding police officers and medical rescue is critical. The evidence that the response in the Grant case may have been slightly delayed as a result of poor coordination suggested the need for additional fact-finding and analysis of this issue and a possible remedial plan.

Delays in Investigation and Review

This case was marked by the same delays we have seen repeatedly in the investigative and review processes for critical incidents. The five month period between the completion of the IA investigation and the date of the Commander's Memorandum is particularly concerning.

August 28, 2006 ◦ Scott Suran

On August 27, 2006, the Portland Police Bureau distributed a "Detectives Bulletin" notifying PPB officers as well as other local law enforcement that Scott Suran, a 44-year old white male was suspected of being responsible for a series of strong arm robberies of restaurants in the Portland area. On August 28, at about 3:15 in the afternoon, a man meeting the description attempted to rob the Galaxy restaurant at NE 9th Avenue and Burnside Street but fled the restaurant when the cashier he had threatened with a handgun ran away screaming. PPB Detectives concluded that Suran was the probable suspect and the Bureau of Emergency Communications (BOEC) issued a dispatch to that effect. A detective who responded to the scene broadcast that a civilian witness had seen the suspect heading eastbound from the restaurant in a red Ford Aerostar van. Officers were dispatched to possible routes heading eastward from the Galaxy toward Clackamas County.

About 15 minutes after the attempted robbery, an officer spotted a red van heading south on I-205, saw that the driver resembled Suran, and confirmed the license plate was the one listed in the Detective's Bulletin. He broadcast his sighting and went in pursuit with his lights and sirens activated. A patrol sergeant heard the officer's status over the radio and advised BOEC that he would monitor the pursuit. He authorized three more patrol vehicles to join the pursuit and requested an Air unit and a K-9 unit. The officer caught up to the suspect van and attempted a Pursuit Intervention Technique ("PIT") maneuver with his patrol vehicle to try to nudge the suspect vehicle's back bumper sideways to cause the van to spin out of control and come to a stop. The officer's vehicle made contact with the van, but the maneuver was unsuccessful and the van continued onward. A short distance later, the suspect and the pursuing patrol cars encountered some traffic and had to slow down. Another officer requested authorization to try a rolling roadblock to box the suspect in and allow other officers to catch up with him. The sergeant monitoring the pursuit denied this request, but traffic soon slowed anyway. The suspect drove down the highway shoulder and took the Johnson Creek off ramp into city streets. The original pursuing officer was able to catch up to the suspect van again and employed the PIT maneuver. This time the van spun 180 degrees, struck the street curb with its back tire, flipped onto its side and skidded along the street for some distance, then began to catch fire as it came to a stop.

As officers took positions of cover, they saw Scott Suran kick out the back window of the van and flee on foot into the neighborhood. The original pursuing officer observed what he believed was a gun in Mr. Suran's hand as he fled the van. He along with three other officers engaged in a foot pursuit. Suran went through backyards and jumped over fences. The officers tried to keep within visible range while staying back and exercising caution before going over fences or around corners. The officers lost sight of Mr. Suran but then saw him bolting from behind a backyard shed.

By that time, two additional officers, including Officer Anthony Passadore, had joined the foot pursuit and were close to the shed. They saw Mr. Suran run and took the lead running after him and ordering him to show his hands. Officer Passadore was closest to Suran and saw him holding his hands near his waistband. Then, as he ran, Suran turned his head around to look at his pursuers. Officer Passadore took this as a clear signal that Mr. Suran was going to draw his gun and shoot at the officers. Officer Passadore fired two rounds at him from the AR-15 rifle he was carrying. Mr. Suran was hit in the right side and the right shoulder. He ran a little further, stopped, sank to his knees, and then fell on his back. The officers were able to get Mr. Suran handcuffed quickly and the medical response that had been called for approximately one minute after shots were fired, was then called to the scene three minutes later. No weapon was found on Mr. Suran or along the foot pursuit route. A partially destroyed replica handgun was found in the burnt remains of his red van. Mr. Suran recovered from his injuries and was prosecuted for multiple robberies.

Timeline of Investigation and Review

8/28/06	Date of Incident
[undated]	Clackamas County Major Crimes Team Detective's investigation completed
[undated]	DA declines to present to Grand Jury
2/12/07	IA Investigation completed
11/29/07	Training Division Review completed
2/25/08	Commander's Findings completed
4/16/08	Use of Force Review Board

Analysis/Issues Presented

Vehicle Pursuit Policy and Techniques

When they commenced the pursuit of Mr. Suran's van, PPB Officers had more information than is frequently the case at the outset of such pursuits. They believed that the suspect had committed a string of robberies using a gun and that he had just attempted to add to that string, again with a gun. Under PPB pursuit policy, this justified lights and sirens, potentially a high speed pursuit. When Mr. Suran refused to yield and took evasive action that could reasonably have increased the officers' apprehension that the suspect was highly motivated to avoid capture. The pursuing officers sought to employ two aggressive vehicle pursuit techniques that are allowed by PPB policy. The first was the "box-in" technique whereby officers coordinate their vehicle speed and positions, surround the suspect vehicle, and then slow down simultaneously to bring the suspect vehicle to a stop. The sergeant managing the vehicle pursuit denied the request to deploy the box-in technique because the suspect was traveling too fast, and was believed to have a gun.

The second technique was the PIT maneuver. The original pursuing officer did not request permission to use the PIT but announced his intention to do so well before both of his attempts to use it to bring the chase to a stop. The PIT that eventually ended the pursuit was executed by the officer at the upper limit of the recommended speed for the maneuver and ultimately caused the suspect van to flip and catch fire. This is clearly not the desired outcome for the use of the PIT, but the Training Division reviewers nonetheless determined that the decision to PIT the suspect van was consistent with Bureau training and the speed was justified by the known dangers posed by the suspect. The reviewers point out that PPB doctrine advises officers, after a successful PIT, to continue past the stopped suspect vehicle "to get out of harm's way downrange, stop [oncoming] vehicle traffic, and/or provide a visual deterrent to one of [the suspect's] possible escape routes." The officer did not follow this doctrine but instead decided to stop short of the van. The training analysis concluded that this decision "did not create an issue in this incident because of the great distance the van traveled on its side after being PITted."

In addition, there was no apparent Bureau discussion regarding the divergence from the anticipated and desired outcome of the PIT maneuver. A more introspective look at this incident would have attempted to more carefully calculate the speed at which the van was traveling at the time of the maneuver and

to determine whether there was something about the execution of the PIT that caused the result. That type of robust review may have led the Bureau to consider whether their protocols regarding the upper speed at which the PIT is authorized should be reduced or whether higher profile vehicles such as vans or SUVs presented particular challenges to the deployment of the technique. Unfortunately, the Bureau did not use the review process to discuss these potential lessons learned.

The vehicle pursuit covered a total of about five and one-half miles and ended in Clackamas County. From an early stage, it was monitored and coordinated by a sergeant who also drove in the general direction of the pursuit and was able to arrive at the terminus soon after the shooting.

Foot Pursuit

The foot pursuit preceding the shooting covered several hundred yards through mixed terrain including backyards, bushes, wooden fences, houses, townhouses and a small office building. The pursuing officers did not always stay in visual contact with one another while trying both to monitor the movements of the suspect and to fan out and contain the suspect. When Officer Passadore and his partner entered the scene they drove to the far end of the foot pursuit area and began from there, eventually finding themselves closest to the suspect.

The Training Division Review concluded that the officers pursued Mr. Suran in a manner consistent with PPB training and implied that the risks taken during the pursuit were more than justified by the presumed danger posed by Mr. Suran. The analysis, however, never broke down the complicated multi-officer pursuit into its component parts and sequence of tactical decisions, instead focusing on one officer's intention to use his Taser if he got an opportunity and then his accidental loss of the Taser along the route.

Officer Passadore asserted that he and his partner initially intended to find and hold a perimeter position to help contain the suspect. This intention to establish a containment position is arguably supported by Officer Passadore's decision to take his AR-15 rifle out of the patrol car rather than rely on his handgun, even though, by his own admission, it is not safe to run fast with the rifle. But, as Officer Passadore approached the position, he saw Mr. Suran run and disappear between two buildings. He and his partner gave chase and crept around a small wooden shed to try to determine where Mr. Suran was. A thud and yelling from a third officer nearby alerted them to the fact that Suran was just a few feet away on

the other side of the shed. Mr. Suran took off running and came into Officer Passadore's view. He and his partner gave chase. Officer Passadore said that he wanted to keep the suspect in sight but did not want to get too close, and was also worried about the threat to citizens in the surrounding area. Despite his purported caution, Officer Passadore stayed within 20 to 25 feet of Mr. Suran until the moment when Officer Passadore stopped and fired two rounds.

It is clear from the investigation that some officers involved in the foot pursuit had only intermittent knowledge of each other's locations or where the suspect was at any given moment. The justification invoked by several officers including Officer Passadore when describing what amounted to a precipitous and disorganized chase is that Mr. Suran was known to be armed and desperate and could resort to hostage-taking if he got close to residences. One officer even cited a notorious well-known incident years earlier where a fleeing suspect broke into a home and took a child hostage, eventually resulting in the death of the child. This tragic memory, however, had only speculative relevance to the Suran pursuit and did not alter PPB doctrine at the time, which cautioned:

> *Pursuing an armed subject puts the officer(s) at a tactical disadvantage and will greatly increase risk factors. If information about the subject…possibly being armed is received during the pursuit, officer(s) should change their tactical plan to deal with the additional risk factors an armed subject presents.*[4]

Officer Passadore had lost sight of Mr. Suran at least once during the pursuit and his partner lost sight of the suspect at least twice. Each time this happened, each officer paused and carefully worked their way around the corner using standard police techniques. Yet, just before the shooting, Officer Passadore justified staying close to Mr. Suran because he said if he lost sight of Suran as he went over a berm at the top of the rise, he would have to abandon the pursuit. As it turned out, the close proximity created the split second decision-making situation that caused Officer Passadore to feel he had to shoot the suspect whose only change in behavior was to turn his head to look at Officer Passadore as they ran. These inconsistencies and the potential drawbacks of approaching the suspect so closely appear to constitute the central tactical questions of this shooting of an

[4] PPB Training Division In-Service 2005-06 Tactical Update Foot Pursuits, Lesson Plan Outline and Presentation.

unarmed suspect, yet they were not addressed in either the Detectives' lengthy interview of Officer Passadore[5] or in the Training Division Review.

PPB did not have a formal foot pursuit policy at the time of this incident. The officers directly involved in the pursuit of Mr. Suran, however, had recently received a detailed in-service training focusing on tactical and safety considerations in foot pursuits quoted above. This is not esoteric doctrine but rather a mainstream best practice. The current foot pursuit policy adopted three years after this incident includes a litany of prohibitions or cautionary admonitions to discourage some of the tactical decisions made during the Suran foot pursuit. [See discussion of foot pursuits in general below in Common Issues section.]

Viewed through the lens of the Bureau's current, much improved foot pursuit doctrine, the pursuit of Mr. Suran, especially by Officer Passadore and his partner, was a rash attempt to catch a suspected fleeing armed robber. As a result, Officer Passadore placed himself in such close proximity to the suspect that he felt he had no option other than to use deadly force when Mr. Suran looked back at him.

Post Incident and Control of the Crime Scene

The immediate post-incident tasks at the crime scene were well coordinated. The sergeant who had monitored the pursuit from the outset arrived at the shooting scene immediately after the shooting, ensured that a medical unit had been requested, assigned officers to secure the area and canvass for civilian witnesses, and had the involved officers separated and readied for transport to the station that would serve as the base for the investigation. Two of those officers agreed to narrate a walk-through of the scene and pathway of the foot pursuit with detectives, which helped provide a detailed early picture of the incident and facilitated a comprehensive search for any weapons the suspect might have dropped or discarded.

But there were many officers on the scene and some miscues. An officer who arrived at the crime scene after the shooting observed that one of the patrol cars was parked in the sun. Not realizing that the vehicle had been involved in the pursuit, and in an effort to be helpful, he drove it into the shade. When the scene commander sergeant noticed this, he admonished the officer to place the patrol car back where it was originally. By moving the car before the scene had been

[5] This officer interview was conducted by Milwaukie Police Department detectives.

photographed and documented, the officer committed a basic error in scene control and evidence preservation, especially since, at that time, he would have had virtually no knowledge of what had transpired at the scene. But by instructing the officer to put the car back in position, the sergeant compounded these problems, because it would have been impossible to reposition the car precisely at its original position. These events, which fortunately turned out to be of minor significance to the more important aspects of the evidence, nevertheless raise questions about whether the Bureau placed sufficient emphasis on the objectives and the practice of crime scene control. We note that the Bureau's 2013 in-service training for all sworn personnel emphasized "crime scene management" but the curriculum did not appear to address the important subcategory of officer-involved shootings.

Recommendation 17: The Bureau should ensure that field personnel understand that its training curriculum and doctrine regarding the importance of crime scene management, the preservation of evidence and the integrity of the scene apply to officer-involved shooting scenes.

Inter-Agency Issues

The pursuit by PPB officers entered Clackamas County, where the pursuit ended and the shooting took place. It was initially determined that the officer-involved shooting investigation would be handled by the Clackamas County Major Crimes Team with participation from Oregon City Police Department, Milwaukie Police Department, and Portland Police Bureau.

There is no indication that there was any disharmony among the participating agencies, but the team approach can sometimes raise questions. The interview of the shooter officer – arguably the key interview of nearly all officer-involved shootings – was conducted by an Oregon City PD detective and a Milwaukie PD detective. It is thorough and balanced but the detectives allude to an extensive pre-interview that took place off tape. Even if the contents of a long pre-interview are innocuous, it is a preferable practice to tape record all parts of the interview. This issue was also raised with the Bureau by the Police Assessment Resource Center (PARC) as early as 2003. The PARC Report from that year recommended that, "[t]he PPB's policy and practice of conducting unrecorded "pre-interviews" of officers or civilians should be eliminated."[6] As a follow up,

[6] "The Portland Police Bureau: Officer-Involved Shootings and In-Custody Deaths," Police Resource Center, August 2003, Recommendation 4.15, p. 84.

in their 2005 Report, PARC reported with approval that, "[p]re-interviews of both PPB members and civilians have been eliminated.…These provisions represent a significant and appropriate improvement…"[7]

We recognize that, in this instance, detectives from other agencies conducted the interview of Officer Passadore, but this does not do away with PPB's stated interest in ensuring that a procedural reform to which it has made a commitment is followed.

Recommendation 18: The Bureau should continue to raise with the constituent agencies of the Major Crimes Team the issue of pre-interviewing officers involved in critical incidents and advocate for the adoption of its own consistent standard of avoiding unrecorded "pre-interviews."

Major Crimes Team members also interviewed the civilian witnesses in a small office building overlooking key parts of the foot pursuit route. The civilian witnesses had seen parts of the pursuit, as well as heard shouted commands and the shots fired. Unfortunately, these interviews were cursory and confused as to the chain of events and the locations pointed out by the witnesses. There were no follow up interviews.

PPB Internal Affairs investigators did not re-interview the involved officers as part of their subsequent investigation. This was consistent with a common PPB practice at the time and, as we noted in our First Report, this procedure has been revised since. Having IA conduct re-interviews of involved officers is an especially relevant reform of PPB procedure where an incident such as this is handled by a multi-agency team. It is important for the Bureau to have the opportunity to ask its officers questions about their rationale and tactical decision-making that relate specifically to the particular policies and training of PPB.

Quality of Training Division Review

The Training Division Review laid out most of the important tactical issues in this incident and analyzed most officer and supervisor actions relative to Bureau policy and training. The analysts are generally reasonable and flexible in their

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[7] "The Portland Police Bureau: Officer-Involved Shootings and In-Custody Deaths, First Follow-Up Report," Police Resource Center, August 2005, Recommendation p. 40.

evaluation of high pressure decisions in the field but point out tactics that were less than optimal.

The main departure from this analytical rigor, however, is the discussion of the decision to shoot. The analysis points out that Officer Passadore's main reason to shoot was that he saw Mr. Suran's hand repeatedly go to his waist area and he saw him turn around to look at his pursuers only once, thereby indicating that he might be trying to acquire a target on which to use his presumed firearm. In addition to this, the officer cites the suspect's refusal to stop and his proximity to residences as the other factors justifying the use of deadly force. While these latter factors arguably correspond to a component of the minimal deadly force standard established by the U.S. Supreme Court,[8] the Portland Police Bureau policy on the use of "Deadly Physical Force" is notably more restrictive. It allows for officers to use deadly force on a fleeing suspect to affect his capture or prevent his escape only when the officer "has probable cause to believe that the suspect poses a significant *and immediate* threat of death or serious physical injury to the member [of PPB] or others." [emphasis added.] In the context of the circumstances of this shooting, the perceived plausible *immediate* threat was to the pursuing officers only. Therefore, the proximity to residences is not relevant to the question of whether the use of deadly force complied with PPB policy. Moreover, it is likely that in the City of Portland, virtually all suspected armed suspects will be running where residences, schools, parks, and the like are nearby and a suspect could potentially take a hostage. As a result, Officer Passadore's rationale and concern for the danger of the community, if accepted, could be used to justify the use of deadly force to resolve virtually all foot pursuits in the City where officers believe the suspect to be armed.

Moreover, the training analysis does not put these decision factors into the context created in part by Officer Passadore's decisions. When Officer Passadore and his partner officer arrived at the scene, the four other officers were already engaged in a foot pursuit. Officer Passadore and his partner did not know the exact location of the suspect but had heard reports indicating his general direction of flight so they decided to try to take a position to contain the suspect rather than catch him. This conforms to PPB pursuit doctrine when the suspect is believed to be armed, yet the two officers then started searching closely around a backyard shed because they thought he might be hiding there. When the suspect bolted from the opposite side of the shed, Officer Passadore ran after him yelling orders to show his hands

[8] *Tennessee v. Garner*, 471 U.S. 1 (1985).

and, by the officer's own estimate, coming within 25 feet of Mr. Suran. Officer Passadore had no cover and, when Mr. Suran kept his hands near his waist and turned his head as he ran to look at the officer, the officer perceived this as a prelude to pulling out a gun. Officer Passadore fired two rounds at the fleeing suspect.

From the descriptions of the other involved officers, it appears that, before this final phase of the pursuit, Mr. Suran eluded the officers for a short time and the foot pursuit may at some point have ceased to be a pursuit and become a search, thus implicating different policies than the ones relied upon to justify the pursuit. This possibility is not addressed in the Training Division Review.

There are other tactical questions that the analysis does not address, including Officer Passadore's decision, when he caught up to the terminus of the vehicle pursuit, to drive another block past the crashed suspect van and into the active foot pursuit scene. This raises an officer safety issue as do Officer Passadore's and his partner's close quarters attempt to see if Mr. Suran was on the other side of the small shed and Officer Passadore's foot race with the suspect across an open field. Officer Passadore chose to run after the suspect he believed to be armed while himself carrying a more cumbersome rifle, which allows for greater accuracy at a farther distance. This might have offered the officer an advantage over the suspect whom he presumed to be armed with a handgun, but closing the distance on the Mr. Suran diminished that potential advantage. While the community protection considerations were clearly prominent in the minds of the officers and are front and center in the training analysis, they are not balanced with the officer safety considerations. The fact that the suspect turned out to be unarmed should not diminish those safety concerns, especially for purposes of raising future training issues.

November 12, 2006 ◦ David Hughes

On November12, 2006, at around six o'clock in the morning, PPB dispatch received an anonymous tip that David Hughes was staying in a room at the Hospitality Inn on SW Capital Highway. Hughes had an outstanding warrant for unlawful use of a firearm that carried $1 million bail. Three Central Precinct officers responded to the motel and knocked on the door to the room where Mr. Hughes allegedly was staying. They received no response and heard no sign of movement in the room, so they left after instructing the desk clerk to call if she saw Mr. Hughes return.

Later that morning, following a PPB shift change, the motel clerk called dispatch to advise that Mr. Hughes was in the motel room. When the Bureau of Emergency Communications (BOEC) broadcast the radio call, a Northeast Precinct officer recognized Mr. Hughes' name from previous contact. He advised Central Precinct officers that Mr. Hughes was known to carry firearms, and that he had said something to the effect that he would not go back to jail without a fight. Officer Kevin Tully was dispatched as the primary officer on the call. Four other Central Precinct officers, including Officer Nathan Voeller, assigned themselves to the call as backup. Sergeant Timothy Musgrave was the field supervisor at the time, and also responded to the call. The officers communicated via radio and chose a meeting spot in a parking lot near the motel but concealed from view.

While en route, Sergeant Musgrave received additional information from the Northeast Precinct officer, as well as another sergeant, that Northeast Precinct officers had determined that they would activate SERT for any response to Mr. Hughes' home (located in Northeast). Musgrave also learned from these sources that Mr. Hughes' was suicidal, in that he had stated he would die before going to prison. Further, the Northeast Precinct officer informed Sergeant Musgrave that he had built a pretty good rapport with Mr. Hughes and that he would be willing to talk to him if that opportunity arose during the course of the call.

Officers met at the predetermined location to discuss their plan for approaching the motel. They intended to make some efforts to learn whether Mr. Hughes was in fact in his room and then call in SERT to handle the apprehension. While they were still assembling and just beginning to talk, one of the officers called the motel clerk to gain further information. During the course of their discussion, the clerk informed the officer that Mr. Hughes had just fled out the window of his motel room. Without any further discussion, officers got into their cars to drive

across the street to the motel in what one officer described as an "organized scramble."

Officers quickly spotted Mr. Hughes on one side of the motel, essentially trapped between that building and a pizza parlor, with the eight-foot gap between the two structures covered by a six-foot chain link fence on each side. Sergeant Musgrave and Officers Voeller and Tully confronted him at one end of the enclosure. Officer Voeller was armed with an AR-15 rifle, while the other two had their handguns drawn. A fourth officer was armed with a less-lethal beanbag shotgun. There were two other officers on scene – one was attempting unsuccessfully to enter the pizza parlor to gain a different vantage point; the other remained on the periphery without a weapon drawn, largely because the other officers already crowded the field. Officers were approximately five to ten yards away from the suspect.

The officers commanded Mr. Hughes to put his hands up in the air. He responded that he couldn't raise his left arm[9] and yelled back at the officers something to the effect of "go ahead and shoot me." Mr. Hughes reached into his jacket with his right hand three times. Each time, the officers were concerned about the possibility of him retrieving a gun, but believed the movements were not purposeful enough to constitute a deadly threat. Following these actions, though, officers reported that Mr. Hughes made a different motion, reaching under his jacket toward his rear waistband with greater deliberation than the previous times. Officers had varying perceptions about who fired first, but Voeller, Tully, and Musgrave each discharged their weapons at about the same time. The designated less-lethal officer also responded to the threat by firing one round from the weapon he had available, the beanbag shotgun. This round apparently was blocked by the chain link fence. Witness officers reported that the beanbag round was fired moments before the lethal rounds.

Mr. Hughes dropped to the ground and was initially still, but as officers gave commands for him to put his hands up, he made another deliberate motion toward his hip area, and officers responded with another volley of shots. Mr. Hughes suffered a total of nine gunshot wounds, to his chest, abdomen, legs, arm, and back. Officers attempted to retrieve keys to open the gate into the fenced area, but ultimately used bolt cutters to gain access to Mr. Hughes. They made a tactical approach, cuffed him, and rendered first aid within approximately five

[9] This proved to be true, as the autopsy results confirmed that Mr. Hughes' arm was fractured, most likely as the result of the jump from his second-floor motel room.

minutes. Paramedics transported him to the hospital, where he was pronounced dead. Mr. Hughes was unarmed.

After Mr. Hughes' death, the PPB learned that shortly before he fled the motel room, Mr. Hughes made at least two phone calls. One was to a local television station, during which he told the reporter with whom he spoke to send a news crew to the motel because the police were going to kill him. He told the reporter he wanted to speak with the Northeast Precinct officer with whom he had built a rapport (and who he identified by name). He also made a 911 call during which he asked to speak to this officer. None of this information was communicated to the on-scene officers.

In addition, Mr. Hughes sent several text messages – apparent suicide messages – to his daughter shortly before his encounter with police. In those messages, among other things, he stated that he forgives whoever gets him and asked her to give a message to the Northeast Precinct officer (again, who he identified by name) to watch over his daughter and "never go dirty."

Timeline of Investigation and Review

11/12/2006	Date of Incident
11/26/2006	Grand Jury proceedings
8/1/2007	IA Investigation completed
8/25/2007	Commander's Findings completed
10/15/2008	Use of Force Review Board

Analysis/Issues Presented

Tactical Planning and Decision-making

Sergeant Musgrave stated that he intended to learn whether Mr. Hughes was in the motel room, and then planned to activate SERT. Because this issue was not a focus of Detectives' investigation and he was not interviewed by IA, Sergeant Musgrave's plan for confirming Mr. Hughes' presence was never explored during the course of the investigation, so it is difficult to critique that plan. Ideally, SERT would enter into a situation such as this while it still had the element of surprise so that SERT officers could have greater control over the timing of a confrontation. Based on the timeline of calls he made, Mr. Hughes somehow either became aware or suspected that the police knew his whereabouts even prior to the officers' arrival. He fled before officers had the opportunity to begin to develop a plan. As a result, the decision to not immediately contact SERT became inconsequential in this case.

After Mr. Hughes fled through the back window of his motel room, events unfolded rapidly. Officers confronted Mr. Hughes through the chain link fence and showed some degree of patience with the initial movements of his hands inside his jacket before firing when he made a more purposeful movement toward his rear waistband. The Commander's Findings memo and the Use of Force Review Board focused on the decision to use deadly force and did not discuss any of the tactical decision-making leading up to that use of force.

The reviewers did not question why officers so quickly engaged Mr. Hughes. Given the information they had – that he was likely armed and considering "suicide by cop" – one question that could have been asked and examined during the investigation and review was whether officers could have held positions of cover while containing Mr. Hughes inside the fenced-in area between the motel and the pizza parlor. While these positions of cover would have compromised officers' ability to see Mr. Hughes, the sergeant could have directed officers to take positions on the roof or through a window of either building to maintain a visual perspective on the suspect. Slowing the incident down in this manner could have allowed for more structured communication with Mr. Hughes, utilization of SERT resources, and perhaps intervention by the Northeast officer who had earlier volunteered to speak to Mr. Hughes, and whom Hughes had been seeking through his earlier 911 call.

The Training Division Review likewise did not consider this possible alternative scenario, but suggested the sergeant made the correct decision to immediately confront Mr. Hughes.

Sergeant's Role

As the field supervisor of the officers assigned to handle the call regarding Mr. Hughes, Sergeant Musgrave recognized the seriousness of the call and appropriately responded to supervise. As events rapidly unfolded, however, the sergeant seemed to lose sight of his supervisory role and instead assumed a tactical position alongside his officers, ultimately firing his weapon at Mr. Hughes. In a situation such as this, where there are a sufficient number of responding officers who can tactically engage the suspect, the better practice is for the sergeant to step back and provide direction to the officers. Had the sergeant done that here, he might have recognized that Mr. Hughes was essentially barricaded in the fenced-in area while the officers were positioned dangerously close in exposed positions confronting an individual they believed to be armed. He may have recognized that the beanbag shotgun would not be effective through the chain-link fence and directed that officer to re-deploy. In short, he may have been able to slow down this incident, provide the opportunity to consider the tactical alternatives discussed above, and engage a negotiation team that could have included the Northeast officer who was familiar with Mr. Hughes and who had offered to assist. Following the shooting, the sergeant did follow his training and performed well coordinating resources and directing the formation of a custody team.

Dispatch Issues

Mr. Hughes called 911 approximately half an hour before the desk clerk at the motel notified Central Precinct that Hughes was back in his room. At that time, Hughes said his motel room was surrounded by police and asked to speak with the Northeast Precinct officer with whom he had prior contact. The BOEC dispatcher grew impatient with Mr. Hughes, told him "we don't do personal calls on 911," and ended the call without further follow up. She did not put the call together with the earlier anonymous call to 911, did not relay the call to Central Precinct, and did not contact the Northeast officer for additional information.

Approximately 30 minutes later, the motel clerk called BOEC's non-emergency line to report that the man officers had been looking for earlier was back in the room. The clerk told the dispatcher that Hughes was in his room and that he was

"freaking out" because the cops were looking for him, had him surrounded, and were banging on the walls. The BOEC operator put this information together with the earlier anonymous call and relayed the information to Central Precinct officers. Unfortunately, Hughes' paranoia about a police presence (there were not actually any officers at or around the motel at the time of his call) did not seem to be a factor in the officers' response.

The Bureau does not operate BOEC, which is a separate City of Portland function. The Central Precinct Commander who authored the Commander's Findings memo following this shooting recommended that BOEC supervisors review this incident because the decision to end the call from Mr. Hughes without any follow up "appears flawed." There is no evidence in the documents we reviewed that the Bureau or BOEC followed up on this issue.

Recommendation 19: The City and Bureau should consider ways to formally bring BOEC supervisors or decision makers into the Police Review Board process in cases where a BOEC dispatcher's judgment or performance is potentially at issue.

Post-Shooting Response

Unlike some of the cases discussed in our First Report and in the Vaida shooting in this report, in which it took officers more than 30 minutes to render medical aid to downed subjects, this case was notable for how quickly officers got to Mr. Hughes to render aid. Here, officers moved quickly, without a SERT callout or the use of a ballistic shield, to move toward Mr. Hughes, handcuff him, and allow paramedics access. This was true even though many of the alleged justifications for delay we saw in those other cases likewise were present here – officers did not know if Mr. Hughes was armed and had not yet secured the motel room whose window overlooked the shooting scene. We do not mean to suggest that officers acted inappropriately in moving so quickly. On the contrary, the officers' quick response was commendable. It is notable, however, that the perhaps overly extreme caution displayed after other officer-involved shootings that occurred contemporaneously with or after this shooting was deemed to be consistent with training and within Bureau policy, while the speed with which officers moved here was barely mentioned in the review documents.

Sequestration of Shooter and Witness Officers

Following the shooting, each of the involved officers was paired with an uninvolved officer and, per policy, remained at the scene until released by detectives. The officers were gathered at a nearby restaurant, which also became a staging area for logistical coordination. The investigation did not reveal any specific misconduct or taint that occurred as a result of this failure to properly sequester the involved officers. Nonetheless, the Commanders' Findings memo recognized the impropriety of this, and that officers need to be sequestered at a location where no one other than Detectives' Division has access.

East County Major Crimes Task Force

We recommended in our First Report that the Bureau reconsider the 2006 PARC recommendation with regard to the deployment of the East County Major Crimes Task Force in response to officer-involved shootings. In this 2006 case, the Task Force conducted a number of interviews. While those interviews were not as problematic as we noted in our First Report, here a non-Bureau member of the Task Force interviewed Sgt. Musgrave. While that interview was sufficient, it was not as tight and thorough as the interviews of the other shooter officers conducted by a PPB Detective.

Quality of Investigation and Review

Ineffective Use of Crime Scene Diagrams

As we noted in our discussion of several cases in our First Report and in the Vaida shooting discussed in this report, Detectives did not use crime scene diagrams effectively. Detectives here did not make clear the locations of various officers during the incident. While they sometimes referred 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.

Lack of Independent Follow Up Work by Internal Affairs

Following the completion of the Detectives' investigation and presentation to the grand jury, this case was referred to an IA investigator. He conducted five interviews, including the three Central Precinct officers who responded to the

motel at the end of their night shift and did not locate Mr. Hughes, their sergeant, and the officer who fired the less-lethal shotgun at Mr. Hughes. IA did not re-interview the two officers and sergeant who fired lethal rounds at Mr. Hughes, nor any of the other civilian or officer witnesses. While the Detectives' interviews were thorough, so that there was little need to re-interview civilian witnesses, there were clearly issues relating to policy, training, and tactics about which the investigator should have questioned the witness and involved officers. For example, Sergeant Musgrave was not questioned about how he intended to ascertain Mr. Hughes' location before contacting SERT, nor the tactical alternatives this scenario presented.

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 our First Report, IA revised its written Standard Operating Procedure specifically to require this expanded scope of review.

Delays in Investigation

Despite the fact that the IA investigator did very little work on this case, it took him eight months to complete his investigation. There is no apparent explanation for this delay in the case file.

By contrast, the post-IA review process for this case was completed in a timely manner. The Commanders' Review was completed in three weeks, and the Use of Force Review Board convened to discuss it approximately six weeks later.

Quality of Training Division Review

As noted above, the Training Division Review failed to address any tactical alternatives to the officers' immediate engagement of Mr. Hughes. We noted a similar deficiency in some of the Training Division Reviews we analyzed in our First Report, but also noted a general evolution toward Reviews that engage in more critical analysis of tactical decision-making and the decision to use deadly force.

The Review did identify several other issues regarding officers' tactical performance and recommended that these become the subject of future training scenarios:

- Officers did not fully contain Mr. Hughes by covering each side of the fenced-in area. One car with two officers went to the opposite side of the fence, but then circled back once they saw their fellow officers engaging Mr. Hughes.
- Officers did not immediately recognize that the motel room from which Mr. Hughes had jumped had not been secured, and that anyone in the room had a clear line of vision onto the shooting scene.
- Officers were fully exposed with no cover when they confronted Mr. Hughes.
- The Recommendations section stated that the Bureau should continue to provide supervisors training on the capabilities and uses of the AR-15 rifle in tactical situations. The Review did not state why this recommendation was made, or whether Training believed the AR-15 was used properly here. It is fair to question, however, whether the use of at AR-15 to confront a suspect approximately five to ten yards away is an optimal use of that weapon.

August 24, 2009 ◦ Osmar Lovaina-Bermudez

On August 21, 2009, the PPB determined that four recent armed robberies were attributable to one suspect, later identified as Osmar Lovaina-Bermudez (Bermudez), and issued a Detective's Bulletin to local law enforcement personnel stating that an unnamed "armed serial robber" had robbed four restaurants or bars in the last 10 days. It gave a rough description of the suspect and included surveillance camera pictures. One patrol officer read the bulletin and also had a conversation with a robbery detective about the suspect and his crime pattern, which included use of a dark colored revolver during the robbery and fleeing on foot to a waiting vehicle.

On August 24, 2009, at about 5:30 p.m., the Red Apple Tavern and Bar in northeast Portland was robbed by a lone Hispanic male who displayed a handgun and spoke with a Spanish accent. PPB officers were dispatched to the scene. The patrol officer who had earlier read and discussed the bulletin heard the call and contacted the robbery detective; they agreed that this crime shared many characteristics with the other robberies attributed to the serial robber. The patrol officer decided to station himself about a mile from the scene on the hunch that the robber might still be in the area. Soon thereafter, he saw a man he believed was the suspect go by in the passenger seat of a maroon Ford van. He followed the van without activating his lights and siren and called for backup officers. At one point, the officer pulled up next to the van and confirmed that the passenger appeared to be the suspected serial robber. After about a mile, the suspect van turned onto a dead end portion of SE Pine Street west of SE 172nd Avenue. The officer turned on his lights and siren to initiate a traffic stop. The van stopped and the officer ordered the driver and the passenger to put their hands up. The driver started to get out of the van but then returned to the driver's seat. The passenger got out of the van and fled southwest past the dead end into a group of residences bordering on a small mobile home park to the west. The officer maintained cover of the van driver, then took him into custody when backup officers arrived.

The officers set up a perimeter to contain the fleeing suspect and the watch commander decided to activate PPB's Special Emergency Response Team (SERT). After a few minutes and the determination that the scene was actually within Gresham Police Department territory near East Burnside Street, PPB SERT was told to stand down and Gresham SWAT was activated. But very shortly, after brief discussions between Gresham PD and PPB, SERT was re-activated to assist Gresham SWAT. This occurred at shortly after 7:00 p.m. The

SERT team assembled at a command post a block from the dead end street where they were briefed about the identity and appearance of the suspect, the circumstances of the most recent armed robbery and other prior robberies. They were given a photograph of Mr. Bermudez and told that no weapon had been recovered from the van search.

Portland Police Bureau SERT members and Gresham Police Department SWAT members devised a search plan that put SERT on the east, north and west sides of a rectangle bounded by two small streets and a mobile home park, respectively. SWAT formed along the southern border, a wide multi-lane street. The plan was to have SWAT push up from the south once SERT had completed their search of the yards and areas between the houses and apartments and around the mobile homes within the rectangle. During the SERT search, the team with the K9 discovered a windowless, metal backyard shed where the dog alerted. As the dog began standing up and scratching against the sides of the shed, officers yelled commands in English and Spanish for the suspect, whom they presumed might be inside, to come out showing his hands. In reply, they heard the suspect yell, "Fuck you," and state that he would shoot the dog if it came inside. The team with the K9 broadcast the location of the suspect in the shed as well as his statements.

The suspect opened the door of the shed several times and peeked out briefly, carrying a large piece of cardboard or carpet before him to obscure his head and part of his body, and then retreated back inside and shut the door. He ignored orders to show his hands and come out. After a few of these episodes, officers were able to confirm that the black object he held in his hand in addition to the cardboard was a gun. Officers also broadcast this information.

In response to this information, the SERT sergeant shifted the team which was west and north of the shed and put one pair of rifle operators behind each of two large fir trees pointing their guns east in case the suspect fled in their direction. This team also evacuated two of the mobile homes that might be in the line of fire if an exchange of rounds occurred.

A Hostage Negotiation Team (HNT) was on the scene and had obtained what they believed to be Mr. Bermudez's cell phone number. They hoped to initiate negotiations with the trapped suspect and called Mr. Bermudez a couple of times when he was inside the shed, but he did not pick up the call.

The officers near the front of the shed concluded that tear gas might be an effective method to extract the suspect from the shed. They asked their sergeant if they could deploy gas. He in turn sought and obtained permission from the lieutenant providing incident command. The officer with the "cold gas" launcher, which was able to penetrate light walls, fired six canisters into the shed. The officer with the "warm gas" launcher, which disperses more gas but has less penetrating capability, fired only one round, which dented the side of the shed then fell to the ground emitting gas. Rather than surrender and come out the door of the shed, Mr. Bermudez kicked through a back seam of the metal walls of the shed, escaped out of the hole and fled to the east, running through two back yards and over two fences. Officers in another location spotted the suspect running and broadcast his direction of flight.

When Mr. Bermudez reached the six- to seven-foot tall opaque wooden fence separating the second yard from the edge of the mobile home park, he put his hands over the top of the fence and began to hoist himself up. Officer Russell Corno and his partner – the two-officer rifle team behind a fir tree a few yards from the fence – could not see his approach but heard about his movements over the radio. They both saw that Bermudez held a revolver in one of his hands as he pulled himself up over the fence. The officers perceived the gun to be pointing at them. Each officer said he believed that he and his partner were in grave danger and prepared to fire. Officer Corno fired first through the fence boards, firing three rounds and hitting Mr. Bermudez twice. Mr. Bermudez immediately fell back off the fence and was no longer visible to the officers. The second officer held his fire.

Other officers positioned elsewhere could see Mr. Bermudez laying on the ground and crying out in pain. A small black revolver was lying near Mr. Bermudez where he had fallen. They yelled orders at him, which he followed. He was handcuffed, given immediate medical attention at the scene, and then transported by ambulance to the hospital. He had received two gunshot wounds to the upper chest. He survived his wounds.

Four days after the incident, this case was presented to the Multnomah County Grand Jury, which found no criminal culpability by Officer Corno. Mr. Bermudez was indicted by the grand jury for multiple crimes including six counts of robbery with a firearm as well as charges related to his attempt to escape from the police and possession of methamphetamine. Mr. Bermudez was not charged

with brandishing a firearm or assault on police officers stemming from his actions at the fence just prior to being shot.

Timeline of Investigation and Review

8/24/09	Date of Incident
8/28/09 - 9/1/09	Grand Jury proceedings
9/15/09	Detectives' Investigation completed
1/11/10	IA Investigation completed
2/22/10	Commander's Findings completed
4/20/10	Training Division Review completed
4/21/10	Use of Force Review Board

Analysis/Issues Presented

SERT Tactics

The chronology of events, activations, and command and control of resources at the scene appeared to have been methodical and businesslike up to the moment when Mr. Bermudez broke out of the back of the shed, climbed a fence, sprinted across two backyards and was shot climbing over a fence by officers stationed at the perimeter. Mr. Bermudez's escape from the back of the metal shed was clearly unanticipated. There was no less lethal ordnance to use against him as he sprinted across back yards and over fences and the K9 was not released in time to catch him. By the time the two officers behind a fir tree at the perimeter were able to determine exactly where the fleeing suspect was, he was climbing over a fence a few yards in front of them and, as they perceived it, pointing a gun in their direction. They both prepared to fire. Officer Corno's partner ultimately held fire only because Corno, his partner on the other side of the tree, fired first.

Officers in an operation of this nature may have to improvise with whatever cover is available to them at the location. The officers with gas launchers facing the

front of the metal shed felt exposed once they confirmed that Mr. Bermudez was inside and he was armed. An officer went back to the armored vehicles for ballistic shields for his team but found only one. To the west, Officer Corno and his partner took cover behind a large tree trunk and positioned themselves to take advantage of the fact that one of them was right-handed and the other left-handed. Despite this stout cover, these two officers felt vulnerable enough when the suspect started to come over the fence in front of them to feel compelled to shoot.

Two of the three rounds fired at Mr. Bermudez hit him in the chest. The third lodged in the corner fence post. One of the rounds that hit Mr. Bermudez passed through his torso and hit the sliding glass back door of a residence, passed inside and lodged in a fireplace. The documentation on whether this residence had in fact been evacuated, as the shooter officer believed, is equivocal.

The construction of the perimeter and the execution of the search appeared to have been well coordinated and efficient, especially considering the daunting challenges posed by inter-agency coordination, the halting initiation of the two-agency effort, and the size and complexity of the scene within the perimeter. This is partly attributable to good, real-time communication throughout. As officers on the scene tell it, they were immediately aware of all new developments as the incident unfolded. One significant shortcoming in the planning and placement of officers was the failure to anticipate the suspect's escape out of the back of the metal shed. No one on scene described having a clear view of the rear of the shed as Mr. Bermudez kicked a hole in it and climbed out, nor were any officers in a position to confront him with less lethal weapons or a visual presence before he began to run.

This brief moment of confusion may have been due in part to the tear gas released outside the shed when the warm gas canister failed to penetrate the metal. As the officer who fired the canister acknowledged he knew, warm gas rounds do not have the penetrating power of cold gas rounds. Indeed, the SERT officer who deployed the warm gas was dubious of the canister's ability to penetrate inside the shed, but he did not voice this concern and appeared by his own admission to be anxious to do something that would contribute to the capture of the suspect. Additionally, he was encouraged by another officer to fire the warm gas because there were no more cold gas launchers. As the officer might have expected, this decision to fire the warm gas was counterproductive. There was no evidence that this officer was remediated or counseled about his deployment of the warm gas,

or reminded that taking ill-advised action just because you want to be in the action is not consistent with professional police practices.

Within a few seconds of the deployment of gas, there was a rapid, unpredictable and violent resolution of the incident. This fact requires significant scrutiny of the failed attempts at negotiation when officers first discovered Mr. Bermudez in the shed. When HNT's initial efforts to communicate with the suspect via cell phone failed, the team apparently did not try other approaches such as loudspeaker hailing or finding a third party with whom Mr. Bermudez might have been more willing to speak. SERT's decision to shoot gas into the shed effectively ended any effort to negotiate with the suspect.

There appears to have been no meaningful impediment to SERT and HNT utilizing their tactical advantages and employing the slower, low risk options of either waiting the suspect out or renewing or revising attempts to communicate with him. A frequent admonition of critical incident and special weapons and tactics experts is to take advantage of those situations where time is on your side. This can run counter to the strong impulse to resolve a potentially violent situation quickly but often reduces the need to use deadly force in the long run.

Better communication between the components of SERT, HNT, and the tactical teams may have helped provide for a more deliberate approach. In his candid after action critique, the HNT sergeant at the scene noted that HNT negotiators' decision to try the cell phone was not coordinated with the rest of SERT and that this tactical shortcoming should be a topic of future discussions.

Inter-agency communications were not a critical factor in this event because PPB personnel were the primary officers involved in contacting Mr. Bermudez. Nevertheless, an after action report by the critical incident commander alludes to the command and control glitches that remain in the multi-agency situations often encountered in Portland. He opined that the limited experience of a working relationship between PPB and Gresham PD "probably led to some delay in reaching a tactical plan, planning communications, and beginning a search for the subject."

Recommendation 20: The Bureau should ensure that field personnel who may have occasion to use special equipment such as ballistic shields and gas canisters are trained on their availability and location.

Use of the K9

SERT employs police dogs to assist with containment operations. A K9 officer and his dog – a German shepherd trained to search for hiding suspects – were a natural choice for this operation. Indeed, the K9 quickly found the suspect in poor light in a closed metal shed, one of several similar structures within a large and complicated perimeter that also included mobile homes, houses, apartment buildings, wooden decks with spaces underneath, vehicles, and dozens of other potential hiding places. Had the K9 not alerted on the shed, an officer might have had to open it without knowing that there was an armed suspect inside.

When the suspect heard the dog scratching, he threatened to shoot the dog, thereby confirming that he at least claimed to have a gun. The dog's handler pulled the dog back as soon as Mr. Bermudez threatened to shoot it. Because the suspect thereafter was able to escape from the shed and cross back yards and climb over fences before encountering perimeter officers at a location where they felt they had no choice but to use firearms, this raises the question of whether releasing the dog to chase and possibly halt or bring Mr. Bermudez to the ground as he ran might have helped resolve the incident without further threat of harm to the suspect or officers. It is discernible from the reports and interviews in the Internal Affairs investigation that an attempt was made to release the K9 to apprehend the running suspect after he broke out of the shed but, by the time this occurred, the suspect was out of sight and the dog did not know which way he had gone. Clearly, the K9 officer and other officers nearby did not realize Mr. Bermudez had broken out of the back of the shed and run until it was too late for the dog to be of use.

Alternative tactical decisions that might have allowed the K9 officer and others to anticipate the rear escape route or to become aware of the suspect's flight more quickly are not addressed in the investigative reports or Training Division Review. The feasibility of alternative scenarios is always subject to debate. Because the ideal outcome of searching for a dangerous felony suspect is to apprehend the suspect while preserving the safety of officers and the suspect as much as possible, the Bureau should have engaged in a discussion of such alternative possible scenarios. Unfortunately, there is no indication that the alternative or additional deployment of K9s was considered or questioned by IA, the Commander's Findings Memorandum, or the Training analysis.

The deployment of the gas during this incident foreclosed further attempts to negotiate with the suspect. The gas also appeared to contribute to the fact that the

K9 handler was not able to release the dog in time to pursue the suspect and when released, the dog may not have been able to see the suspect's direction of flight.

Recommendation 21: SERT training should emphasize that, in a barricade situation, it may be preferable to exhaust less dynamic and unpredictable tools – such as negotiation and K9s – before introducing gas.

Medical Attention to the Wounded Suspect

Emergency medics were applying life saving measures to Mr. Bermudez almost from the moment he was safely handcuffed. A PPB officer assisted medical professionals by helping to remove clothing and open gauze packs. This appeared to be an admirably swift, well-rehearsed response by SERT personnel that is a clear expression of SERT's emergency medical capability. Officers with EMT expertise are part of all SERT teams. In this incident, they were driving the armored vehicles and were ready to perform life saving techniques as soon as the suspect was secured.

Quality of Investigation and Review

Failure to Use Pictures and Diagrams

PPB detectives and Gresham Police Department detectives formed small teams together to conduct most of the post-incident interviews. The PPB detectives and their ad hoc Gresham Police Department partners were able to interview a large number of involved and witness officers and civilians in a timely fashion after the shooting. They occasionally provided aerial photos to assist witnesses with their narratives of the scene. They asked several officers to draw diagrams of the key points in the geography. These photos and diagrams and the interview transcripts that they accompany are rendered virtually useless as a geographically specific guide to the actions leading up to and during the shooting because detectives never describe the witnesses' gestures for the record or tie the directions given by the witness to specific locations on the photo, map or diagram. This loss of fresh detail is especially pronounced in the interview of the sergeant largely responsible for the organization of the SERT deployment. This sergeant gave a comprehensive description of who went where, what was visible to each group of officers, how the SERT vehicles were moved around, etc. Statements like the

following could be a valuable part of the incident record but the interviewers fail to tie the sergeant's references to the relevant specific locations:

> *So we initially put the Cat up here with [an Officer] in the turret, he had a view this way…We cleared around a couple of these trailers and back to the fence line and then…we deployed teams back holding the perimeter along this, basically like so.*

This problem is only partly mitigated by the practice of videotaping interviews in compliance with state law, for even on videotape, it is rarely clear to what part of a picture or diagram a witness is referring.

Failure to Conduct Effective Interviews of Civilian Witnesses

In addition to the officers at the scene, the detectives identified and interviewed four civilian witnesses the day after the shooting, all occupants of mobile homes who had not been evacuated. One interview stands out because the witness stated that he had seen two police officers fire guns in front of his window, apparently at the suspect. He stated that he saw the muzzle flashes and that this occurred after the gas was launched. The location of this officer, as described by the witness, was inconsistent with the actions of the shooter officer behind the fir tree. No other witness corroborated these observations and there were no shells or other physical evidence found to corroborate the witness' statements. The detectives opined that this witness' observations were "flawed." The interview was conducted in Spanish using a police sergeant to translate. Language confusion is nevertheless obvious during the questions and answers. As a vivid anomaly among the witnesses, this witness should have been re-interviewed later using a neutral translator, if not by the detectives then at least by Internal Affairs. Another of the civilian witnesses heard rather than saw the action, but mentioned his friend "Kevin" who had taken pictures of the scene. "Kevin" was not interviewed and there was no indication of a follow up effort to find him by the detectives or by Internal Affairs during the administrative investigation. IA investigators, for their part, did not attempt to interview any of the civilian witnesses.

Recommendation 22: Investigation supervisors should ensure that adequate follow up is done by administrative investigators to obtain potentially relevant information from civilian witnesses.

Internal Affairs Investigation

The IA investigation of this incident was representative of recent years, showing much more rigor and detail than those from some of the earlier shootings we have reviewed or incidents where there was no substantive IA investigation at all. The IA investigation started later than necessary – five weeks after the criminal investigation by detectives was complete and almost two months after the Grand Jury proceedings – but was completed in less than three months. Moreover, it was reasonably thorough. The only conspicuous absences are any follow up interviews of the civilian witnesses. Unfortunately, in choosing to rely entirely on the detective interviews of the civilians, IA must live with the apparent language translation problems described above and their lost opportunities (for example, the failure to locate "Kevin").

Internal Affairs made a considerable effort to try to include Mr. Bermudez's input in their investigation. Knowing that he had been hostile to Detectives shortly after the shooting and refused to be interviewed by them, and that Mr. Bermudez was now represented by a criminal attorney and a civil attorney, they tread cautiously and attempted to work through the attorneys to obtain Mr. Bermudez' statement. Even though they were ultimately rebuffed, it was appropriate to engage in the effort. The criminal attorney did offer the possibility that he might authorize an interview following the resolution of Mr. Bermudez's criminal trial, but there was no indication that IA ultimately followed up on this possibility.

In general, IA investigators did a thorough job exploring the state of mind of the various SERT officers. Officer Corno and his partner, for instance, convey vividly how close the fence Mr. Bermudez was attempting to climb was to the tree that was their position of cover. IA investigators, however, did not explore the question of whether it was tactically prudent to choose a position so close to the opaque fence behind which a suspect could move about without detection or if they had other options for cover. The Training Review does not tackle this question either, despite the fact that close proximity is cited by both officers as a major reason to decide to shoot immediately. The IA interviews also bring out the presumption on the part of some SERT personnel that, based on past experience, introducing gas into the small confines of the shed would cause the suspect to give up and come out.

Training Division Review

The Training Division Review, completed in 2010, exhibits the newer, highly structured format the Bureau uses that examines each phase of the operation in a methodical manner. It recognizes the swift but intricate preparations made by SERT supervisors before the officers were deployed to the scene. It also points out that, once the operation was under way, supervisors were able to modify plans because of their flexibility and the prompt conveyance of new information as it developed. Its most prominent departure from earlier Training reviews, however, is that it does not skirt around the central trigger-pull issues but addresses them squarely and frankly. It assesses the reasonableness of the officer's expressed state of mind and his intentional failure to provide any further warnings to the suspect before shooting.

Curiously, the Training Review notes the possible "field of fire" problem, in that one of the shooter officer's bullets passed through Mr. Bermudez's body and wound up in the house behind him. But the Review makes no further comment or recommendation regarding field of fire. The Training Review lauds the prudent use of ballistic shields to provide portable cover, but does not mention that some of the SERT officers did not have ballistic shields where and when they wanted them. The review also declined to grapple with the one truly unplanned event – Mr. Bermudez's escape through a hole he had broken in the back of the shed when it began to fill with tear gas. Perhaps this is a tacit acknowledgment that not every contingency can be anticipated and that it was reasonable to assume that escape out of the back of the windowless shed was unlikely. The Review's bland, technical treatment of the decision to launch gas into the shed also fails to take on the critical issue of timing. The Training Division Review fails to address the central and most troubling questions in this case: What was the rush, and were there preferable alternative scenarios that could have been encouraged by slowing the action down?

May 12, 2010 ◦ Keaton Otis

On May 12, 2010, officers with the Bureau's Hotspot Enforcement Action Team ("HEAT")[10] initiated a traffic stop of a car driven by Keaton Otis. The officers had just left a team meeting and coffee break near the beginning of their shift and were driving unmarked patrol cars in close proximity to each other. Driving northbound on Grand Avenue from Hoyt Street, an officer noticed Mr. Otis in the car traveling directly in front of them. The first thing that drew this lead officer's attention was that Mr. Otis looked directly at him in a manner as if he was saying to himself, "do they know what I know?" The officer communicated in his various interviews an acknowledgement that people often are nervous when they see police officers but that Mr. Otis's look was different in its constancy and intensity. Mr. Otis continued to look at him in this manner, not focusing on the road, as he continued driving. The officer also noticed that Mr. Otis was wearing a hooded sweatshirt with the hood up on a day that he described as uncomfortably warm for him in his long-sleeve uniform shirt and was slouching in the driver's seat with his head just above the window. He also stated in his various interviews that Mr. Otis did not seem to "fit" the car, in that the car seemed like one his grandmother would drive rather than one driven by a young man about his own age. He commented in his Detectives' interview that Mr. Otis looked like he could be a gangster and, given the entirety of this scenario, he came to the conclusion that something was not right in Mr. Otis's car. The officer also recognized that Mr. Otis was African-American, but stated in his IA interview that race did not play any role in his ultimate decision to stop the car because, based on all the other things he had seen, he would have had the same suspicions about the car and its driver regardless of his race, ethnicity, or sex.

Officer James DeFrain was riding in the passenger seat of the lead officer's car. He was on his phone and did not make the same initial observations as his partner. Officer Cody Berne, traveling alone in a separate unmarked patrol car, noticed Mr. Otis's vehicle as he drove past Officer Berne, who was waiting to pull into the street. Officer Berne noticed that Mr. Otis was wearing a hooded sweatshirt with the hood up, which struck him as unusual for a warm Portland day. He also noticed that the car – a Toyota Corolla – was of a type that younger men do not

[10] In 2010, HEAT was a unit of seven officers and one sergeant working under direction of the Chief's office to target particular areas of the city or types of crime. Most of the time, its efforts focused on suppressing gang violence with a particular emphasis on youth gangs. To distinguish the team from the Gang Enforcement Team, HEAT officers always worked in uniform. The unit has since been disbanded.

typically drive. He decided to run the license plate and learned that the car was registered to a 50- or 51-year old woman. Officer Berne also noticed that the driver of the car was African-American.

The officers continued to follow Mr. Otis's vehicle while they discussed whether to stop him for an observed minor lane change violation. Mr. Otis then made several aggressive, sweeping lane changes across multiple lanes of traffic, leaving the officers no doubt they had probable cause to initiate the traffic stop. After officers activated their lights, Mr. Otis continued driving at a slow rate, approximately 15-25 miles per hour, but did not pull over. Officers used their air horns and sirens and, though Mr. Otis appeared to still be looking right at them, he did not pull over. He slowed at one point and pulled to the curb, but then accelerated away again. Officers reported that Mr. Otis was moving around inside his vehicle, leading them to question whether he was trying to conceal contraband or retrieve a weapon. Officers also stated that, based on their experience, they believed the driver may have been slow in pulling over because he was devising a plan to attempt to flee on foot.

During this time, Officer DeFrain broadcast that they were conducting a traffic stop and Officer Berne broadcast that he was a cover officer. The other four members of HEAT – traveling in two separate cars – heard the sirens in the background of that broadcast and, as they had all been part of the same team meeting and were still close by, responded as backup.

Moments later, Mr. Otis brought his vehicle to a complete stop near the intersection of Sixth Avenue and Halsey Street. The three officers exited their vehicles with the intent to detain him for attempting to flee or elude a police officer. As they approached Mr. Otis's car, the officers heard Mr. Otis screaming profanities at them, by some accounts referencing his race and the race of the officers. The lead officer formally requested cover officers to respond. Officer DeFrain unholstered his duty weapon as he approached. Officer Berne initially went to the passenger's side door, per standard traffic stop procedure, but moved to the driver's side to join the other two officers when he saw DeFrain's gun out and recognized the volatility of the situation. Mr. Otis also saw Officer DeFrain's drawn weapon and seemed to fixate on it, yelling at him to put it away. The initial lead officer drew his Taser.

The string of profanities from Mr. Otis continued as the lead officer gave commands for him to place his hands on his head. Mr. Otis ignored these commands and ultimately said words to the effect of, "you're going to have to

come and get me." Mr. Otis continued to move inside the vehicle, and at more than one point, plunged his right hand out of sight into the console or passenger's area. Officer DeFrain said he was sure Mr. Otis was reaching for a gun and at one point considered firing at him, but then realized his hand remained empty. At one point, Mr. Otis grabbed the steering wheel and DeFrain briefly holstered his weapon in an attempt to de-escalate the situation and alleviate Mr. Otis's anger about the gun. He attempted to speak to Mr. Otis in a softer tone, but Otis remained fixated on the gun, repeatedly shouting at Officer DeFrain to "get your hand off your gun." Officers also heard Mr. Otis make reference to his race – African-American – and theirs – Caucasian.

The three other HEAT officers and one sergeant arrived within minutes, with one car boxing in Mr. Otis's vehicle, as requested by the lead officer, to prevent him from fleeing. Six officers were eventually gathered around the driver's side door while Officer DeFrain and another responding officer decided to attempt to physically remove Mr. Otis from the vehicle. The other officer reached through the window and grabbed Mr. Otis's right hand in an attempt to apply a control hold while Officer DeFrain opened the driver's door intending to take hold of his other arm and pull him out of the car.

Mr. Otis was able to break free from the officer's grasp and lunged toward the glove compartment. The sergeant fired his Taser, as did the initial lead officer and a third officer. It is not clear how many of the Taser probes actually made contact with Mr. Otis's skin and in what positions.[11] The Tasers had an immediate but only temporary effect on Mr. Otis, who continued moving toward the glove compartment. He produced a Crown Royale bag and, within seconds, officers heard what they believed was two gunshots and the officer who had attempted to pull Mr. Otis from the vehicle went down. Officers DeFrain and Berne immediately returned fire while the others retreated, sought cover, and went to the downed officer's aid, eventually getting him into a car and driving him to the hospital.

[11] A Taser weapon deploys two probes that stay connected to the weapon by fine wires that conduct an electric current. When both probes or darts come into contact with the target's skin, it completes a circuit and sends intense signals through the victim's nervous system, disrupting voluntary control of muscles that results in strong involuntary muscle contractions. This incapacitates the subject in a way that cannot be overcome until the electricity stops flowing, at which point the subject immediately regains control of his or her body.

Officers DeFrain and Berne fired eight to 10 and 11 rounds, respectively, and then stopped as they saw Mr. Otis move toward the passenger's side door. Officer DeFrain fired five to seven more rounds, because, he said, he could not see Mr. Otis's hands and was concerned he would either turn and continue shooting or would exit the vehicle and re-engage officers. Officer Andy Polas had been standing behind other officers at the time of their initial engagement. He moved toward a position of cover behind a radio car while he continued to watch Mr. Otis. He did not believe Mr. Otis had been disabled by the officers' initial rounds and saw him trying to get out of the passenger's door, so he fired six rounds through the rear window of Mr. Otis's vehicle at about the same time Officer DeFrain was firing his second burst of rounds. Officer DeFrain then raised his hand and shouted, "stop" several times, and no more rounds were fired. Officers called for paramedics.

Officers saw continued movement from Mr. Otis and, because they could not see his gun or his hands, the sergeant initially made the decision to activate SERT in order to take him into custody. Very shortly thereafter, though, the sergeant realized Mr. Otis was no longer moving and decided to immediately secure him and seek medical aid. He assembled a custody team and instructed one member to fire three beanbag rounds at Mr. Otis, who was non-responsive to each. The team moved in, pulled Mr. Otis from the car and handcuffed him, approximately six minutes after the shooting. Medical personnel arrived less than two minutes later. Mr. Otis was pronounced dead at the scene. Mr. Otis suffered 23 gunshot wounds from a total of 32 rounds fired by the three shooter officers.

Officers located a nine millimeter semi-automatic Taurus PT111 pistol[12] on the passenger seat of Mr. Otis's car. All of the involved officers deployed nine millimeter Glock pistols. The Crown Royal bag was found on the sidewalk near Mr. Otis's body. According to a report from the Oregon State Police Crime Lab, numerous shell casings found at the scene had characteristics consistent with having been fired from a Glock pistol. One shell casing was found inside Mr. Otis's vehicle that had markings indicating it had been fired from a Taurus pistol. One bullet was recovered outside the vehicle that was determined by the Oregon State Police Crime Lab to have been fired from the Taurus pistol found inside Mr.

[12] This gun was registered to an individual who reported he had been burglarized in 2006. He reported at the time that several firearms had been stolen, but did not specifically report the Taurus PT111 to be among them. When interviewed, he said he must have overlooked that omission from the report, but stated he had not seen that particular firearm since the 2006 burglary.

Otis's vehicle. DNA on that bullet matched the wounded officer's DNA. It does not appear that the Bureau conducted a gunshot residue test on Mr. Otis, nor did Detectives attempt to match fingerprints from the Taurus PT111 to Mr. Otis.

Detectives interviewed more than 30 witnesses, talked to numerous others to determine if they had seen anything, and recovered personal video footage from two witnesses. While witness statements varied as to exact statements and words overheard and precise placement of various officers, the witnesses generally gave consistent statements about key events. One witness account varied widely from the others. She stated Mr. Otis was cooperative with officers' commands, but that officers assaulted Mr. Otis for 15 to 20 minutes, during which time he was pleading with her to help because the officers were going to kill him. She said she could see Mr. Otis's hands at all times, and that he never had a gun. She said officers tased him and shot him for no reason. The cell phone video recorded by one witness conclusively refutes this witness' account.

Timeline of Investigation and Review

5/12/2010	Date of Incident
5/21/2010 - 5/26/2010	Grand Jury proceedings
7/22/2010	Case assigned to IA investigators
10/13/2010	Initial IA Investigation completed
4/6/2011	Final IA Investigation completed
4/18/2011	Case sent to Commander for Review
5/23/2011	Initial Commander's Findings Completed
9/13/2011	Commander's Findings completed
10/5/2011	Use of Force Review Board

Analysis/Issues Presented

Concerns about Racial Profiling or Bias-Based Policing

Community concerns about this shooting centered on the officers' basis for initiating the traffic stop of Mr. Otis and a belief that it was racially motivated. We commented on similar concerns in our First Report, in the discussion of the shooting of James Jahar Perez. There, 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. While Mr. Otis, like Mr. Perez, was African-American, officers here offered much more detailed justification for why their attention was drawn to Mr. Otis, and why they decided to pull him over. Specifically, the officer who initiated the stop noticed the following:

- A look from Mr. Otis that seemed to say, "do they know what I know?" and suggested to the officer that Mr. Otis may have just committed a crime. When Officer DeFrain questioned his partner about why they would run the license plate of the car, DeFrain reported that his partner said, "if you saw the look this guy just gave me, you'd run it, too;"
- Mr. Otis was wearing a hooded sweatshirt with the hood up on what was described as an uncharacteristically warm day;
- Mr. Otis was slouching in the driver's seat;
- Mr. Otis did not seem to fit the car, in that it seemed like one an older woman and not a young man would drive;
- Mr. Otis looked like he could be a gangster;
- The car was registered to a middle-aged woman (who officers learned later was Mr. Otis's mother).

All of the officers engaged in the decision about whether to stop Mr. Otis's vehicle articulated race-neutral reasons for doing so. In their interviews with Detectives and IA investigators, they demonstrated an understanding of the Bureau's expectations regarding racial profiling in the details they elaborated on to help explain their thought processes regarding this traffic stop. These accounts provide the only available insight into what the officers were thinking at the time.

More important than what initially drew officers' attention to Mr. Otis or the level of detail they offered in articulating their suspicions about him or the car, however, is the basis for the eventual decision to stop and detain Mr. Otis. Once his attention was drawn to the vehicle, the lead officer stated he noticed a minor lane change violation that could have justified a traffic stop, but the officer stated

he could not articulate that violation well and did not feel it was enough to justify detaining the driver. He decided to continue following Mr. Otis to see how his suspicions played out. Ultimately, Mr. Otis's driving was so erratic that one officer stated in his IA interview that any citizen driving down the street would have expected the officers to conduct the traffic stop. In our view, when considering bias-based policing issues, this is the principle distinction between this incident and the shooting of Mr. Perez in 2004, which began when officers stopped Mr. Perez for failing to properly signal before making an otherwise legal turn.

Nonetheless, the fact that some portion of the community believed that this incident began as a racially-motivated traffic stop demonstrates that the Bureau still has work to do in educating its members and communicating with the public on these sensitive issues. Following the Perez shooting in 2004, the Bureau convened an advisory committee and engaged a noted scholar on bias-based policing to develop training for its members. Officers were required to complete a three-hour "Perspectives on Profiling" class dealing with the ethics and constitutionality of traffic stops.

In 2006, the Bureau engaged with community members in a number of listening sessions on racial profiling coordinated by the Mayor and Oregon Action. Following these sessions and the creation of a Racial Profiling Committee that emerged from them, the Bureau published a Plan to Address Racial Profiling in January, 2009. That plan included strategies to (1) increase the diversity among Bureau members; (2) train officers to create better communication skills, better understanding of race relations, improved interpersonal skills, and the ability to more accurately predict criminality and reduce indiscriminate searches; (3) build mutual trust and understanding with community groups; and (4) collect and analyze the right data on police stops.

One outgrowth of the Bureau's Plan to Address Racial Profiling was the formation of the Community and Police Relations Committee (CPRC) within the City's Human Rights Commission. Comprised of five Human Rights Commissioners, five community members, and 5 police officers, the CPRC has worked cooperatively with the Bureau to address the strategies in the Racial Profiling Plan. The Bureau is also working with the City's Office of Equity and Human Rights on a new training program for all officers that addresses historical perspectives on racism both within the Bureau and in society with the hope of

broadening officers' awareness of how current Bureau policies and their own conduct fit within that context.

Tactical Planning and Decision-making

In general, the tactical decisions made during this incident were sound, and reflective of the fact that the HEAT members had regularly worked and trained together as a team. There are, however, several issues worthy of further assessment:

- *"Box-in" maneuver*

Because Mr. Otis had earlier stopped his vehicle and then pulled away again, the officer handling the initial stop requested that the next responding car "box-in" Mr. Otis's car so that he could not drive away. The officers were questioned about this decision during their IA interviews, but concern about the tactic generally subsided when it became clear that Mr. Otis's car was stopped at the time the responding officer boxed him in and that no one attempted to use the "box-in" technique that officers are trained to use in an effort to stop a moving vehicle. Nonetheless, the handling officer's decision to use this version of a "box-in" technique meant that he instructed another officer to stop and exit his patrol vehicle directly in front of a car whose occupant was extremely agitated and whom they believed might be armed. The officer who placed his car in such proximity to Mr. Otis positioned himself at a tactical disadvantage, where he was required to turn his back to what eventually proved to be an armed person. The training analysis dispensed with this officer safety concern by noting that Mr. Otis posed a risk to the community should he be permitted to drive away and prompt a potentially dangerous vehicle pursuit. Under this logic, officers should always proceed to do whatever possible to prevent stopped vehicles from moving, no matter how risky the tactic. This is inconsistent with Bureau policy, training, and philosophy as exhibited, for example, by the restriction of certain tactics in the Bureau's shooting at vehicles policy. In this case, the decision to place an officer in a position of vulnerability during the "box in" maneuver deserved further scrutiny.

- *Decision to Immediately Approach Mr. Otis's Vehicle*

During their brief, low speed pursuit of Mr. Otis, officers observed him making movements inside his car that suggested to them he was either retrieving a weapon or concealing contraband. When the officers got out of their vehicles and

began to approach Mr. Otis, they were immediately met with a string of profanities and a manner they described as hostile and aggressive. Given these two pieces of information, one option that officers could have considered was to maintain positions of cover or concealment and arm themselves appropriately while they attempted to use verbal commands to get Mr. Otis to exit his vehicle. Failing that, they could have treated him as a barricaded suspect and called in additional resources while attempting to de-escalate the situation. This option was not explored in the IA interviews or the Training Division Review.

- *Decision to Try to Pull Mr. Otis from the Vehicle*

During the course of the traffic stop, officers gave numerous commands to Mr. Otis to put his hands up. When these attempts at verbal control were ineffective, officers decided to try to pull Mr. Otis from the vehicle in an effort to gain physical control and separate him from the weapon they believed he might have had in the car. The Training Division Review, while concluding that the decision to try to pull Mr. Otis from the vehicle was consistent with training, states in one place that the officer did not reach into the vehicle, but rather grabbed Mr. Otis's arm as it rested on the open window and in another that the officer reached into the car to grab Mr. Otis's wrist. Regardless, the result was that the officer got pulled into the car, an inherently dangerous and tactically disadvantageous position. Another option would have been for officers to maintain their positions outside the car, with guns and Tasers drawn on Mr. Otis while continuing to give him commands and attempt to get him to come out of the car voluntarily. While officers were understandably concerned that Mr. Otis might have a gun in the car and were eager to separate him from that gun, it is fair to question whether the decision to physically engage Mr. Otis unnecessarily sped up this encounter.

- *The Number of Engaged Officers*

At one point, there were six officers (including the sergeant) gathered around the driver's side of Mr. Otis's vehicle. At least two of them had no ability to reach Mr. Otis or provide any other tactical assistance because of the presence of other officers between them and the car. When Mr. Otis fired, they appropriately retreated for cover. Given that Mr. Otis was already agitated by the police presence, these additional officers may have exacerbated that situation while at the same time placing themselves in harm's way.

- *Cross-fire*

One officer positioned himself on the passenger's side of Mr. Otis's vehicle and fired his Taser into the car from this position. Other officers were not aware this officer had deployed his Taser, and when the gunfire began, this officer was in a dangerous cross-fire situation from which he wisely and quickly retreated.

- *Simultaneous Deployment of Three Tasers*

Two officers and a sergeant deployed Tasers at roughly the same time, though only one of the six darts fired from their three weapons actually penetrated Mr. Otis's skin.[13] While in this incident they had only a minimal and temporary effect, the question has been raised about whether this triple deployment was excessive. The Bureau's Taser policy does not prohibit such simultaneous deployment, and two of the officers who fired their Tasers were not aware that a third officer had also deployed his. This was not a situation where deployment of the Taser or application of the Bureau's policy was questionable. Mr. Otis was actively resisting officers and they believed he was reaching for a weapon. They fired their Tasers in an effort to avoid the use of deadly force.

One officer's statement about the rationale for multiple Taser use indicates insufficient knowledge of how the Taser functions. He indicated that if only one Taser barb struck Mr. Otis, a deployment of a second Taser would achieve the desired effect, even if only one barb from the second Taser struck him. In fact, in order to be effective two barbs from the same Taser have to strike the person.

The Medical Examiner found one Taser dart to have penetrated Mr. Otis's body, his right forearm. Two other darts were noted by the Medical Examiner to have been lodged in Mr. Otis's clothing. Another was found at the scene near Mr. Otis's body, and another lodged in the backseat. It is not clear where the remaining dart landed, but it is likely the Taser deployments were ineffective at stopping Mr. Otis's efforts to reach his weapon because they failed to directly connect with his body. An analysis of all three Tasers indicated they were in good working order, and each had been cycled twice during the encounter with Mr. Otis.

[13] The autopsy reports one Taser dart lodged in Mr. Otis's right forearm, and two others were found to have penetrated his clothing but not his body. It is not clear where the other darts landed.

- *De-escalation Efforts*

Officer DeFrain reported that he made several attempts to de-escalate the tension between police and Mr. Otis by lowering his voice and, at one point, re-holstering his gun in response to Mr. Otis's focus on the gun and his repeated entreaties to "put the fucking gun away." While none of the officers recognized, at the time, that Mr. Otis might be mentally ill, Officer DeFrain stated that this type of de-escalation efforts had worked for him in past encounters with agitated subjects. While these attempts may have temporarily calmed the situation with Mr. Otis, any early de-escalation attempts were likely undermined by the arrival of additional officers.

Sergeant's Role

After the shooting, the sergeant on scene did a good job coordinating resources, directing movement, and planning the effort to take Mr. Otis into custody quickly. During the incident, however, his supervisory role was unclear as he assumed a tactical position and deployed his Taser. During our discussions with Bureau members, we learned this was how the HEAT sergeant typically operated, partnered with an officer and acting much like another team member rather than a field supervisor. The better practice would be to have a sergeant in the field taking charge of the scene from the outset, stepping back and directing another officer to deploy his Taser rather than filling that role himself. Here, the sergeant's personal engagement in the incident prevented him from having a bigger picture view of the entire incident, so that he did not realize, for example, that three Tasers had been deployed simultaneously.

The sergeant here did transition from his role as Taser operator to on-scene commander as the incident unfolded, taking control of radio communications, directing the transport of the injured officer to the hospital, activating SERT, and directing the custody team. However, a sergeant in this scenario preferably would have acted as an incident commander from the outset, directing his officers' actions and positions, keeping them out of cross-fire situations and having some step back into supporting roles rather than have them all crowded around the vehicle.

It is an excellent practice to have a sergeant assigned to a specialized team like HEAT, so that the sergeant can be in the field and respond quickly to supervise tactical situations. However, having that sergeant partner with an officer and

operate essentially like another team member undermines the benefit of that assignment.

Recommendation 23: The Bureau should continue to employ sergeants in the field as critical members of specialized teams, but should also assess the role of these sergeants to ensure that they are acting like supervisors and not participating in operations as regular team members.

Post-Shooting Response

The sergeant in charge of the scene initially did not believe he and his team could safely approach and apprehend Mr. Otis because he could see neither his hands nor his weapon. He activated SERT to assume responsibility for the task, but then reassessed and determined that Mr. Otis was no longer moving. He then assembled a custody team and assigned an officer to fire three beanbag rounds at Mr. Otis. When Mr. Otis did not respond, he directed officers to move in and handcuff him and then allowed paramedics to access the scene.

The six minutes it took from the end of the shooting until Mr. Otis was handcuffed was a short time relative to other PPB cases we have reviewed. As we discussed above relative to the shooting of Mr. Hughes, this was the case even though many of the justifications for delay described in other shootings likewise existed here. Officers knew Mr. Otis had a gun, could not see his hands, and did not have access to a ballistic shield.[14] Nonetheless, officers moved quickly to provide paramedics access to Mr. Otis. As this is the most recent shooting we have reviewed, we are hopeful this quick response is a sign of real progress.

One issue raised during the review of this incident was a concern raised by some members of the public that Mr. Otis's body was left out in the open during the initial shooting investigation. Because he had been pronounced dead at the scene, his body remained at the scene, per policy, until the Medical Examiner's office took custody and removed it several hours later. We found a reference in the Detectives' file to the fact that privacy barriers had been placed around Mr. Otis's body, but did not discover evidence suggesting when these screens had been erected. The Bureau should remain sensitive to this issue and strive to get barriers up as quickly as possible and document their use through photographs following any incident in which there is a delay in removing a citizen's body from the scene.

[14] While sergeants who worked field supervisor positions drove cars equipped with ballistic shields by the time of this shooting, the HEAT sergeant was not among those who was issued a shield.

Quality of Investigation and Review

Investigation by Detectives and Internal Affairs

This case was thoroughly and clearly investigated and documented by both Detectives and Internal Affairs investigators. Regarding the IA investigation, there are two things worth noting. While we commented positively in our First Report on investigators' notable efforts to avoid leading questions, here we found they did at times slip into a pattern of asking some leading questions. However, this was only in those areas that had been covered in the Detectives' interviews, where IA investigators sometimes led the involved officers through their responses in those prior interviews on issues relating to sequence of events and positioning during the shooting. On other issues, such as the motivation for the traffic stop, investigators asked appropriate open-ended questions.

IA investigators also appropriately limited the scope of their work to avoid merely duplicating Detectives' efforts. They interviewed all of the involved officers, but only a few key civilian witnesses. We noted in our review of the shooting of Mr. Campbell that IA investigators re-interviewed all civilian witnesses, but did so telephonically, in a way that proved to be largely redundant and ineffective. In response to our First Report, the Bureau committed to conducting in-person interviews of all relevant witnesses. In this case, completed prior to that report, IA investigators avoided telephonic interviews while concentrating their resources and time on the most critical witnesses.

Quality of Training Division Review

The Training Division Review was well-written and made a number of observations about communications options, shooting mechanics, and the supervisors' role in the use of beanbag rounds to assess the conditions of a downed subject. However, it failed to address some key points that we would have expected to see in the analysis. Notably, the Training Division Review did not include the training records for involved officers relating to racial profiling or bias-based policing issues, nor a discussion of how well officers here applied those training lessons. The analysis also failed to discuss many of the tactical considerations raised above:

- Decision to immediately approach Mr. Otis's vehicle;
- The crowd of officers gathered around the driver's side of Mr. Otis's vehicle;

- Potential cross-fire;
- Simultaneous deployment of three Tasers;
- De-escalation efforts; and
- Sergeant's role.

Based on our conversations with training staff it appears that all these issues were considered and discussed as being consistent with the officers' training. Some were discussed during the Review Board's consideration of the incident. It is not clear why they were not documented in the written Training Division Review.

Delays in Investigation

Detectives quickly completed their investigation and the grand jury's review of the shooting began within ten days of the incident. It then took nearly two months for the case to be assigned to IA investigators, who then completed their initial investigative report within three months. Following that, the Independent Police Review Division (IPR) apparently requested some changes to the final report, and those changes took nearly four additional months to complete. It is unfortunate here that the initial timely investigative work was undermined by subsequent delays in completing a final report.

Delays in Review Process

The delays in the review process are even more troubling than the investigative delays. The case was first sent to the Commander in April, 2011. There is a memo signed by the Commander dated May 23, 2011, that apparently was not sent back to IA until August 19, 2011. Following a request from IPR for a minor modification, there is a final memo dated September 13, 2011. It is not clear whether the Commander initially had his memo completed on May 23, 2011 and bureaucratic processes slowed its delivery or whether that memo is simply misdated. Regardless, preparation and approval of the Commander's Findings took a total of five months, an unacceptably long period of time, particularly because the memo did not offer any new insights into issues not already raised by the Training Division Review. Within three weeks of the Commander's memo, on October 5, 2011, the Review Board was convened. The Board found all aspects of this incident – the traffic stop, the box-in maneuver, Taser use, application of deadly force, post-shooting use of the beanbag shotgun, post-shooting medical attention, and operational planning and supervision – to be within policy.

SECTION TWO

Common Themes and Issues

Use of Tasers

We reported on the use of the Taser in the Perez shooting in our First Report and made recommendations stemming from the circumstances of that incident. Once again, Taser use featured prominently in the incidents reviewed here. In four of the seven incidents reviewed for this report, PPB officers used a Taser. In two of the cases in our First Report, the Taser was also deployed. In all of these six cases, the Taser was ineffective in providing officers with a less lethal disabling weapon that reduced or eliminated the need for use of lethal force. Indeed, in two of the six cases of Taser use, the Taser was applied after the shooting: in the Perez shooting when the backup officer activated the Taser after the shooting and kept it activated for several minutes after backup officers arrived; in the Gwerder shooting when PPB officers used the Taser to determine whether it was safe to approach and handcuff the downed suspect, and in the Young shooting when the Taser was used to determine whether the suspect had been sufficiently incapacitated to make it safe to reach into the suspect's car and put it in park. It is unclear whether the original PPB Taser policy authorizes the Taser to be deployed under these scenarios. Deploying the Taser in this fashion appears to contradict the policy against firing a Taser at someone who is "obviously medically fragile."

In the Perez shooting, we commented that the extreme length of time in which the Taser was activated on Mr. Perez was exponentially above the standard five second cycle but there was no apparent prohibition on this extended deployment under the original policy. These incidents raise the question of whether the Taser is being appropriately and effectively deployed.

- Mr. Perez (First Report) was pulled over in his car. When he behaved erratically and appeared to have something concealed in his pocket, then tried to pull the object out of his pocket, an officer fired three rounds, wounding him fatally. His partner then fired a Taser, overrode the five-second cycle, and kept it activated for over three minutes. Only one of the two Taser darts made contact with Mr. Perez.
- SERT surrounded the house of a possibly suicidal Raymond Gwerder (First Report) and ended up shooting him shortly after he pointed a gun in the direction of the SERT rifle operators taking cover behind his house. Mr. Gwerder fell and lay motionless. When officers moved in to secure him, they fired a Taser at him to determine whether the incapacitated man was still a threat before handcuffing him.
- In the Young incident, the cover officer fired his Taser at the driver of a vehicle that had just come to a stop after a sudden acceleration backwards during which another officer had fired two rounds at the driver. The officer who fired the Taser did so to assess the degree of incapacitation of Mr. Young so that he could reach into the car, put the vehicle in park and help pull the driver out of the car.
- An officer used his Taser in drive stun mode – that is, as a hand-held prod, without firing the darts – on Mr. Grant who resisted the officer's attempts to handcuff him. He applied the Taser to Mr. Grant's back and neck, but was not able to effectuate the handcuffing until backup officers arrived. Using the Taser the way in which the officer did so in this incident only inflicts localized pain rather than disabling large muscle groups.
- After a brief foot pursuit, Mr. Vaida stopped in response to an officer's commands. He raised his hands revealing a gun in his waistband. When Mr. Vaida failed to lie on the ground, the officer's partner fired a Taser at his back. The darts hit Mr. Vaida's coat and he turned and ran again, unimpeded by the Taser.
- Of the seven officers surrounding Mr. Otis's vehicle, three of them held Tasers. All three fired at him through the car windows, just before any firearms were used. One or more of the Tasers had some effect on his

movements but attempts to cycle the Tasers again to disable Mr. Otis were ineffective.

Current PPB policy specifies that all officers and sergeants in uniform assignments should carry the Taser. The Taser may be used in one of three circumstances: 1) where a person resists or attempts to resist a lawful police action, 2) where a person physically attacks or intends to attack, or 3) where a person is suicidal. These criteria were in play at the time of each of the incidents we discuss, but the established policy is not currently where the discussion ends. In September, 2012, the United States Department of Justice (DOJ) issued its finding letter regarding its investigation into whether PPB engaged in a "pattern or practice" of unconstitutional policing. Prominent among DOJ's findings was criticism regarding how the Bureau had deployed the Taser in situations that did not call for its use. DOJ listed several examples of Taser use by PPB where the suspects had not met the constitutionally requisite threat level for its deployment. The six Taser uses we have reviewed thus far could have been additional examples of questionable deployment for similar reasons as the illustrations identified by DOJ.

In response to public concerns, the concerns raised in our First Report and the DOJ findings letter, the PPB drafted a major revision of the Taser use policy – now referred to as the policy on the Electronic Control Weapon System (ECW) – after soliciting input from City officials, the Portland community, and police associations. In February, 2013, the draft was finalized and the new draft policy has been incorporated into recent in-service training.

There are two main innovations in the new draft policy that are relevant to our concerns in this report. The first is the elimination of the "physical resistance or intent to engage in physical resistance" threshold allowing use of the ECW. Instead, the new draft policy's threshold is "active aggression" from the suspect. Second, the draft policy explicitly addresses a suspect's attempt to flee, which the former policy did not discuss. The ECW may only be used now to prevent flight if the "subject presents an immediate threat of physical injury" or if the escape of the subject "presents a significant danger to the public, officers or the subject." In keeping with our evaluation of the Taser uses in this Report, we believe that this rewording is beneficial in that it requires a heightened threshold of Taser use aligned with recent legal standards.

Two other innovations in the new policy restrict the simultaneous use of more than one ECW on a single subject and, arguably, the extended use of a single

ECW for more than two cycles.[15] These are appropriate restrictions in light of the six Taser uses we have reviewed. In the Perez shooting from our First Report, for instance, an activated Taser was applied to the suspect for three continuous minutes, exhausting the bounds of both reasonableness and utility but not explicitly violating any written guidance from the Bureau. The language of these policy restrictions, however, allows for a good deal of interpretation and we are concerned that they may prove to be difficult to enforce. The reference to "cycles" in the new policy, for instance, presumably refers to the automatic five-second energy output cycle that current Taser models employ. This cycle can be extended to many more seconds by depressing the trigger. Furthermore, since the Bureau may want to procure other types of ECWs besides Taser products, it cannot depend on the standard cycle being the same for other types of ECWs.

In 2011, the National Institute of Justice issued a report synthesizing a number of previous independent reports on the human health effects of Taser use and expressing grave misgivings over prolonged uses of the Taser or simultaneous use of multiple Tasers on a single subject.[16] In the Otis incident, an officer who fired one of the three Tasers that were used simultaneously opined that the officers intentionally deployed at least two Tasers together because they incorrectly theorized that if neither of the Tasers connected with both barbed projectiles at least one barb from each Taser might make adequate contact with the suspect and that would have the same disabling effect. In the Grant incident, the officer who used the Taser was apparently unaware of the ability to dart the Taser and then apply the Taser in drive stun mode, creating a circuit that would lock up musculature. These examples show a basic misunderstanding of the Taser's capabilities and suggest a need for more training to ensure that officers possess that knowledge.

Additionally, recent published court opinions have suggested that it may be improper for police to use Tasers absent an imminent threat of harm.[17] These

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[15] "Members should evaluate their force options and give consideration to other force options if an ECW is not effective after two cycles on the same person." (Sec 2.6) "Members will not intentionally activate more than one ECW at a time against a subject if the initial deployment was effective." (Sec. 3.9)

[16] National Institute of Justice, "Study of Deaths Following Electro Muscular Disruption," (May 2011).

[17] E.g., *Bryan v. MacPherson*, 630 F.3d 805 (9th Cir. 2009).

cases may indicate the direction of this developing area of the law. Given the evident recent legal pronouncements raising the prerequisite threat level for permissible Taser use coupled with the frequency of ineffectual use suggested by this sample of incidents, it is timely and commendable that the Portland Police Bureau has re-examined its guidelines and expectations regarding the use of ECWs by officers in order to minimize unnecessary dangers and maximize their tactical utility. As technology, case law and research on operational results evolve, it will behoove the Bureau to view its ECW use policy as a work in progress.

Recommendation 24: The Bureau should consider revising its new ECW policy to strengthen and clarify the admonitions against the sustained use of the ECW.

Recommendation 25: The Bureau's training to accompany the roll out of the new Taser policy should be comprehensive and robust to ensure that officers have a firm and deep understanding of the legal and mechanical limitations of the Taser.

Foot Pursuits

An officer in the field attempts to detain a person. Rather than obey the officer's commands, the person runs from the officer. This scenario is all too common for law enforcement, and guidance to police agencies and their officers on how to respond has evolved over the years. The instinctive reaction and long held tenet was for the officer to give chase and attempt to catch the suspect at all costs. Too many officers still retain this perspective and even more members of the general public expect that officers they pay to keep them safe will chase and apprehend the "bad guy." However, progressive police agencies have learned that to pursue suspects on foot under all circumstances and without caution creates untenable safety risks to their officers, the general public, and those they pursue.

When an officer chases a person on foot, it creates a dynamic that is inherently unsafe. The suspect determines the path of the pursuit. If the suspect is armed, he can draw the officer in and then turn and shoot the pursuing officer before the officer has an opportunity to react. Even worse, if the armed suspect has an opportunity to turn a corner, jump a fence, or enter a structure, and cause the officer to lose visual contact, the suspect then has a tactical advantage over any

pursuing officer and can ambush the officer. Running with an unholstered gun places an officer in a better position to react to an ambush, but creates additional problems, including the possibility of an accidental discharge and hampering the officer's ability to engage in a hand-to-hand fight with the suspect. A long foot pursuit can physically tire out an officer who is weighed down by the necessary gear on his or her belt, and the exhaustion can compromise the officer's tactical skills and decision-making ability. The heightened dangers faced by officers may cause any move by the person being chased to be perceived by the officer as an act of aggression. Because officers are trained to anticipate lethal threats, the stress of a foot pursuit sometimes causes an officer to use deadly force in response to perceived aggression when, in fact, it turns out that the person being chased was not armed after all.

In two of the cases discussed in this report, foot pursuits preceded the use of deadly force. In the Vaida shooting, officers pursued a man suspected of being armed and once they lost sight of him, Mr. Vaida drew a firearm and fired multiple rounds at the lead officer. The officers responded with deadly force. In the Suran shooting, officers attempted to contain Mr. Suran after his van crashed and he fled on foot over fences and in and out of backyards. Two officers eventually pursued Mr. Suran whom they believed to be armed, and when he turned his head, they believed he intended to fire at them, at which time one of the officers shot him with the rifle he was carrying. Mr. Suran was not armed at the time that he was shot.

Largely as a result of the loss of one of its members who was shot and killed pursuing an armed man in 1997, the Portland Police Bureau became attuned earlier than many other agencies to the inherent danger of foot pursuits. As a result of the shooting of its officer, the Bureau presented in-service training to all officers in 1997-98 on the dangers of foot pursuits. Another in-service module on foot pursuits was presented in 2005-06. Finally, in 2009, in-service training was conducted regarding foot pursuits and the Bureau's then-new foot pursuit policy.

The foot pursuit policy, Directive 630.15, provides comprehensive guidance to Bureau officers on safety considerations for determining whether and how to conduct a foot pursuit to minimize the risk to sworn members and citizens:

> *Foot pursuits are inherently dangerous police actions. It is the policy of the Bureau that the safety of sworn members and the public shall be the overriding consideration in determining whether a foot pursuit will be initiated or continued.*

The policy sets out situations in which an officer should not initiate or continue a foot pursuit:

- If a suspect is armed
- If a suspect enters a building, structure, wooded area, or isolated area
- If the danger to the member or the public outweighs the necessity for immediate apprehension
- If the officer is disarmed
- If the officer loses contact with dispatch
- If the officer loses visual contact with the suspect for more than one to two seconds
- If the officer is not familiar with the direction of travel or location
- If instructed by a supervisor to terminate the pursuit

While the policy does set out the basic precepts to be considered and the situations in which foot pursuits should not be initiated or maintained, some language in the current policy creates ambiguity or overbroad exceptions to the restrictions. For example, the restriction on armed suspects authorizes the officer to pursue when "no other alternative strategy is feasible and a delay in the apprehension of the suspect would present a threat of death or serious physical injury to others." The problem with this exception to the restriction is that nearly every armed suspect could be seen by an officer as presenting a threat of death or serious physical injury to others should the suspect be allowed to get away. On the other hand, there will always be an alternative strategy that can be devised rather than chasing the armed suspect. The result is that the exception to the prohibition clouds the guidance provided to the officer regarding under what conditions he or she is authorized to pursue an armed suspect.

In addition, the foot pursuit policy does not discuss the tactical disadvantage when two officers split from each other while engaged in a foot pursuit. The foot pursuit policy also instructs officers that once a foot pursuit is initiated they "should" notify dispatch of the suspect's direction of travel, whether the suspect is armed, the number of fleeing suspects, the reason for the pursuit, and the identification and physical description of the suspect. More progressive foot pursuit policies set out the broadcast of the foot pursuit as mandatory and require the officer to discontinue the pursuit if he or she is unable to broadcast the mandated information.

In our discussion with Bureau leaders on this subject, they appeared hesitant to develop policy mandates regarding foot pursuits, in part because of a concern

about limiting officers' ability to respond to an "active shooter" scenario, where a deranged individual is targeting people in a public place. In our interactions with law enforcement, we frequently hear references to the "active shooter" as a reason officers' actions in the field cannot be too constrained. The argument is that when an individual is shooting up a neighborhood, school, or movie theater, an officer must compromise his or her own safety in order to stop the threat to innocents. In our view, because the "active shooter" scenario is so rare, the Bureau should not hesitate to develop policy or provide guidance requiring officers in foot pursuits to act in conformity with accepted principles of officer safety. The Bureau can always have an "active shooter" exception should it wish to reserve discretion to allow field personnel to set aside officer safety principles when responding to these situations.

Recommendation 26: The Bureau should review its foot pursuit policy and consider whether it should expressly discuss the disadvantages of partner splitting, eliminate potential ambiguity on when armed suspects are to be pursued, and make mandatory radio communication at the initiation of a foot pursuit.

Dealing with Uncooperative Suspects Seated in a Vehicle

In our First Report, we discussed the James Jahar Perez fatal shooting, which was prompted when initial efforts to extract Mr. Perez from a car proved unsuccessful. During that discussion we noted that another shooting with similar issues (the Kendra James shooting) had prompted research on successful approaches for removing people from vehicles. As a result of that research, the 2004-05 Bureau's in-service training included a two hour instructional block entitled "Vehicle Extractions" taught by the Bureau's defensive tactics instructors. In this report, we cite two more cases where the initial attempts to extract a person from his car eventually led to fatal officer-involved shootings.

In our view, police science has paid too little attention to developing successful approaches to extracting uncooperative suspects seated in vehicles. The instinctive reaction of officers to resolve the issue by grabbing the suspect and applying control holds has proven to be a risky maneuver that too many times leads to disastrous results. When an officer goes hands on with a seated suspect, the leverage advantage that the suspect has can lead to the suspect being able to pull the officer into the vehicle. Going hands on with a suspect can hurt the

officer's ability to see what the suspect is doing with his free hand. It often becomes a dicey maneuver for the officer to negotiate the seat belt, the door, and successfully extract an uncooperative suspect, while ensuring that the suspect does not place the car in gear and accelerate away. Grabbing the keys or shift lever of a running vehicle to turn it off or put it in park has led to officers being pulled into the car, increasing the likelihood that they will be dragged or worse, run over as the suspect accelerates away.

As examples of the potential dangers presented to officers when a vehicle extraction has gone wrong we have seen the James, Perez, Young, and Otis situations, all resulting in the use of deadly force. It may be incumbent on the Bureau to again task its tactical experts with developing safer and more effective strategies for extracting uncooperative suspects from vehicles. Some agencies have encouraged officers who are faced with a suspect who refuses to get out of the car to treat the situation as a barricade, back off, seek cover, and call a specialized unit to respond to the location. The Bureau should also consider developing policy that can provide written guidance to its members consistent with its training on how best to deal with uncooperative suspects seated in vehicles. The development of a comprehensive, coherent policy in this area would place the Bureau ahead of most other large cities that similarly lack written guidelines on this continually thorny tactical challenge.

Recommendation 27: The Bureau should task its tactical specialists to develop safer and more effective ways to deal with uncooperative suspects who are seated in vehicles and to articulate these tactical principles in policy.

Vehicle Pursuit Termination Techniques

It is a truism of police work that a suspect who flees from pursuing officers in a vehicle poses significant risks to the welfare of the officers, the public, and himself by driving recklessly and failing to stop. A growing body of research shows that most pursuits are for minor offenses or offenses that are not known to the police pursuers during the pursuit. Best practice calls for caution and clear parameters prior to initiating a pursuit, dispassionate management of the pursuit itself and clear criteria before escalating the danger level or number of participants in the pursuit.

In a recent study published in the FBI Law Enforcement Bulletin, "Evidence Based Decisions on Police Pursuits,"[18] researchers interviewed over a thousand police officers involved in vehicle pursuits, looked at the characteristics and outcomes of the pursuits and concluded that high speed chases are rarely justified given the risks to the general public and to the officers. They also point out that, in the great majority of vehicle pursuits (over 90% in their sample) the suspect is fleeing because of driving a stolen car, or having a suspended license, being under the influence, or to avoid being arrested for reasons unknown to the officers – in short, not violent offenses which are known to the pursuers. It is significant to note that the Suran pursuit was the exception to this pattern. PPB officers had good reason to believe that they were chasing a serial armed robber. The initial officer notified BOEC of the pursuit and the pursuit was managed from the outset by an uninvolved sergeant based on information obtained during the early phase of the pursuit.

The more potentially controversial aspect of the pursuit was its termination as the result of a "PIT maneuver." The PIT – Pursuit Intervention Technique – is a technique whereby a pursuing police vehicle bumps a rear corner of the fleeing vehicle and, ideally, causes it to spin and come to a stop. The technique requires considerable skill and training to be safe and effective. It is also inadvisable to use the technique at high speed. The dividing line established by PPB is 45 miles per hour. Below 45 mph, the technique is authorized as a less lethal use of force; above 45, it is considered deadly force and is therefore prohibited except in extremely rare circumstances. The officer pursuing Mr. Suran considered using the PIT on the highway but did not see an opportunity. Once off the highway, he attempted the PIT unsuccessfully. On his second try, when he was able to execute the necessary controlled collision, he estimated that he and the suspect were going at between 40 and 45 miles per hour. The fact that this maneuver was done at the feather edge of excessive speed had two results: 1) the suspect van spun, hit a curb, toppled on its side, slid for a long distance across the roadway, and caught fire; and 2) the pursuing officer stopped short of the overturned vehicle rather than driving past the impact zone to a point of safety as he was trained.

Some law enforcement departments forbid their officers to use the PIT maneuver, others train their officers to use it. It is undoubtedly a high-risk technique, but statistics indicate that it can be reasonably safe and effective. In one survey of

[18] March 2010, Schultz, Hudak & Alpert.

10,384 vehicle pursuits, the PIT was used 1,018 times, resulting in 35 injuries (3.4%), and no fatalities.[19] Within this context, we note with approval that PPB imposes sensible operational rules on vehicle pursuits and specifically on the use of the PIT maneuver. Whether the Suran incident PIT fell within Bureau guidelines, however, was never definitively determined because the speeds of the "collision" were not analyzed with standard accident reconstruction process. We recommend that, when, as in the Suran incident, the PIT produces results that raise the question of whether the officer complied with the 45 mph limit, the Bureau should follow through with its policy framework and use the tools available – including standard accident reconstruction or its newly acquired GPS capability -- to determine a scientific estimate of the speed rather than relying entirely on the estimate of the officer. This will provide invaluable data to Training and help maximize the safe and effective use of the PIT in future operations. If, in the future, the results of these accident reconstructions show that even at policy-compliant speeds under the 45 mile per hour limit, the outcome is sometimes dangerously unpredictable, then the Bureau should reassess its PIT speed limit in light of the evidence.

Another pursuit termination technique used by Portland Police Bureau is the "box in" tactic utilizing more than one police car to either surround the suspect vehicle and gradually slow it to a stop, or to park on all sides of a stationary vehicle to prevent an anticipated escape. In the Otis incident, the second officer who arrived as Mr. Otis was pulling over believed that he might try to flee so he instructed the third arriving patrol vehicle to park directly in front of the Mr. Otis's car to box him in and prevent him from suddenly driving away as he had done a few moments earlier, after feigning to stop by the curb. At this point, it was not yet known that Mr. Otis had a gun but his erratic, volatile behavior and searching motions in the center console and passenger area raised the officers' apprehensions.

The boxing in technique, especially the stationary version, is simple and effectively prevents the suspect vehicle from fleeing, but it has one significant drawback. It puts the vehicle parking directly in front of the suspect at a perilous tactical disadvantage if the suspect does indeed have a gun. The officer must expose his or her back to the suspect as the officer exits the patrol car. Even if the box in officer were able to point the front of the police vehicle directly at the front of the suspect vehicle, the officer would be much closer to a potentially armed

[19] Schultz, Hudak & Alpert.

suspect than he or she would ordinarily choose to be. As it turned out in the Otis case, the box in officer had time to stop, get out of his car and take a tactical position of his choice before Mr. Otis obtained his gun, but the maneuver always involves a brief period of vulnerability. For this reason, many police agencies forbid it, preferring to run the risks of allowing suspect vehicles an escape route rather than put officers at a heightened risk, if only for a short time. Boxing in is an accepted technique at PPB, therefore we have not seen it examined critically in Training Division Reviews.[20] We recommend that, in future tactical analyses of any incident, boxing in should be recognized as a high risk technique and the relative danger of the technique within the specific circumstances of the incident should be gauged by the Bureau's training and tactics experts.

Recommendation 28: The Bureau should analyze relatively high speed PIT maneuvers to calculate estimated collision speed using all available tools. We further recommend that if these analyses show that PIT maneuver speeds within current permissible limits produce dangerous results, the speed parameter of the Bureau's current PIT policy be reassessed.

Recommendation 29: The Bureau should consider disallowing the box in maneuver where officers have a reasonable belief that the subject is armed with a firearm.

Role of On-Scene Sergeants

In two of the shootings we reviewed for this report – Hughes and Otis – sergeants on scene stepped out of their supervisory roles and assumed tactical positions. In both cases, there was a sufficient number of responding officers to fill these tactical roles. Indeed, in each situation, there were officers on the periphery who described being unable to deploy any weapons because the field in front of them was too crowded with other officers.

Most of the time, officers are called on to act independently and respond to difficult situations without a supervisor present. In the Hughes shooting, the field

[20] PPB's current training materials do, however, point out that "[f]rom an officer's safety standpoint, the Box-In technique is very dangerous. It puts you in close proximity with an unknown or high risk subject." [PPB Lesson Plan – Patrol Tactics – Police Vehicle Operations Box-In, Dec. 2012]

sergeant heard the call for service and, recognizing it was a dangerous situation that potentially involved SERT, he responded along with a number of officers. While he initially took charge of the planning and coordination, when Mr. Hughes' flight cut short that planning process, he responded and engaged with the other officers. The Otis shooting involved the now-disbanded HEAT unit, which was fortunate to have a sergeant assigned directly to it. While that sergeant was the team's supervisor, he spent much of his time partnered with an officer, not in a direct supervisory role. He responded to the traffic stop of Mr. Otis and assumed a tactical position, drawing and ultimately deploying a Taser.

When the Bureau is fortunate enough to have sergeants on the scene of a tactical incident, it should count on those supervisors to take command of the incident and direct resources appropriately. For example, in Hughes, the sergeant could have assessed the situation and directed the officers to take positions of cover while he developed a plan to contain Mr. Hughes. In Otis, the sergeant could have directed another officer to deploy the Taser while he stepped back and recognized the potential cross-fire concerns while re-assessing the need for so many officers crowded around Mr. Otis's vehicle.

Both sergeants did many things right in these incidents, particularly after the shootings – coordinating resources, directing movement of officers and paramedics, and planning the efforts to take the downed suspects into custody quickly. However, in the moments before each shooting, the sergeant's personal engagement in the incident prevented him from having a bigger picture view of the entire incident that would have been preferable to his tactical role.

Based on the current training curriculum for the Critical Incident Management portion of the Sergeant's Academy, the Bureau's training for sergeants does instruct them, generally, to be the team's decision maker, to not do too much by him or herself but to work through his or her officers to resolve the incident. This training for supervisors was overhauled in 2011, largely as part of the corrective action following the shooting of Aaron Campbell. We have no reason to believe this training is ineffective, as both the Hughes and Otis shootings pre-date the change in curriculum. Nonetheless, given the critical role sergeants play in Bureau operations, Training Division should continue to evaluate the effectiveness of its instruction as it reviews future critical incidents.

Recommendation 30: The Bureau should regularly assess the effectiveness of its Sergeant's Academy and Critical Incident Management training for field supervisors and consider whether they adequately instruct sergeants to maintain their supervisory perspective and avoid tactical involvement in incidents in which their officers are involved. The Bureau should hold accountable those supervisors who fail to adhere to these training standards.

Utility of Commander's Findings Memoranda

As we have noted repeatedly in this report and our First Report, the preparation of the Commander's Memorandum often significantly extends the review time for an officer-involved shooting, in one case up to six months. In its September, 2012 findings letter, the United States Department of Justice expressed concerns about the length of the review process for officer-involved shootings. We have been informed that since that time, the City and DOJ have engaged in discussions about setting determinative timelines for when such investigations and reviews are to be completed. In order to meet these new goals, the Bureau will need to look for ways to streamline the investigative and review process of critical incidents.

One option deserving consideration is to eliminate or significantly modify the requirement that the Commander prepare a Memorandum detailing his or her findings regarding officers' performance following an officer-involved shooting. Our review of these memoranda suggests that any incremental value they add to the review process may not be worth the delays they create. And as noted in the Young arbitration case, in situations where the ultimate decision maker disagrees with the initial finding of the Commander, the Memorandum that is prepared can be used later to undercut disciplinary decisions.

It is our understanding that the Commander's Review Memorandum is intended for the involved officers' supervisor to identify potential performance issues and to provide his or her views on whether the officer's performance was consistent with the Bureau's expectations. However, since the Training Division Review similarly identifies issues to be considered by the Review Board, the identification of those issues by the Commander is often duplicative. Additionally, since all officer-involved shootings are forwarded to the Review Board and the Commander attends and participates in the Review Board proceedings, the

Commander has ample opportunity to express his or her views and concerns about the involved officers' performance.

Recommendation 31: The Bureau should consider whether to modify or eliminate the Commander's Memorandum as part of the review process for officer-involved shootings.

SECTION THREE

Recommendations

1 *The Bureau should review current protocols to determine whether they adequately ensure that officers in specialized units are receiving sufficient training regarding perishable skills necessary to perform patrol functions. (Report, p.17)*

2 *The Bureau should consider developing guidelines in its officer-involved shooting protocols to ensure that potential witnesses are not held at the scene for longer than necessary and that any circumstances surrounding a lengthy delay are documented in appropriate reports. (Report, p.21)*

3 *The Bureau should consider refining its Training Division Review protocols to ensure that the analyses include each involved officer's training record and adjudge the officers' performance based on the training provided to them up until the time of the incident. (Report, p.22)*

4 *The Bureau should consider modifying its report writing materials to discourage referring to persons by their first names in police reports and to provide a standard method for distinguishing persons with the same surname. (Report, p.22)*

5 *The Bureau should develop a procedure ensuring that an after-action report is created following arbitration findings to determine whether those findings call for systemic reform. (Report, p.30)*

6 *The City and the Bureau should consider devising written protocols to ensure that employees are notified of any intent to discipline them prior to notifying the general public. (Report, p.31)*

7 *The Bureau should consider developing a written policy statement informing its members that the consequence of any violation of Bureau policy is a potential aggravating factor to be considered in determining the level of discipline to be imposed. (Report, p.32)*

8 *The Bureau should consider revising its directive specifically informing its members that substandard performance and tactics can be a basis for imposing discipline. (Report, p.32)*

9 *The Bureau should revise its directives to expressly state that unsatisfactory performance issues in critical incidents may be significant enough to warrant severe levels of discipline without the usual prerequisite of previous progressive discipline. (Report, p.33)*

10 *The Bureau should implement its current draft policy setting forth the circumstances under which an officer may be relieved of duty or administratively transferred during the pendency of a critical incident investigation, including when the Chief has a reasonable basis to believe that the officer may be terminated. (Report, p.34)*

11 *The Bureau should consider revising its shooting at moving vehicles policy to instruct its members that the policy is intended to cover a wider array of circumstances including the approach to stationary occupied vehicles that are likely to be put into motion. (Report, p.35)*

12 *In termination cases involving multiple allegations, the Bureau should articulate which allegations, if any, individually supports its termination decision. (Report, p.35)*

13 *The Bureau should ensure that command staff recognizes that it should be the overarching objective of every tactical engagement for the Bureau to dictate the outcome. (Report, p.36)*

14 *The Bureau should ensure that its protocols on the handling of persons who die at the scene of a critical incident avoid contaminating the scene while maintaining the person's dignity by keeping them out of public purview. (Report, p.38)*

15 *The Bureau should provide written guidance to its members that disfavors on duty handling of matters involving family members. (Report, p.39)*

16 *The Bureau should provide periodic briefings to field personnel regarding the placement of emergency equipment in patrol vehicles. (Report, p.40)*

17 *The Bureau should ensure that field personnel understand that its training curriculum and doctrine regarding the importance of crime scene management, the preservation of evidence and the integrity of the scene apply to officer-involved shooting scenes. (Report, p.53)*

18 *The Bureau should continue to raise with the constituent agencies of the Major Crimes Team the issue of pre-interviewing officers involved in critical incidents and advocate for the adoption of its own consistent standard of avoiding unrecorded "pre-interviews." (Report, p.54)*

19 *The City and Bureau should consider ways to formally bring BOEC supervisors or decision makers into the Police Review Board process in cases where a BOEC dispatcher's judgment or performance is potentially at issue. (Report, p.62)*

20 *The Bureau should ensure that field personnel who may have occasion to use special equipment such as ballistic shields and gas canisters are trained on their availability and location. (Report, p.72)*

21 *SERT training should emphasize that, in a barricade situation, it may be preferable to exhaust less dynamic and unpredictable tools – such as negotiation and K9s – before introducing gas. (Report, p.74)*

22 *Investigation supervisors should ensure that adequate follow up is done by administrative investigators to obtain potentially relevant information from civilian witnesses. (Report, p.75)*

23 *The Bureau should continue to employ sergeants in the field as critical members of specialized teams, but should also assess the role of these sergeants to ensure that they are acting like supervisors and not participating in operations as regular team members. (Report, p.90)*

24 *The Bureau should consider revising its new ECW policy to strengthen and clarify the admonitions against the sustained use of the ECW. (Report, p.97)*

25 *The Bureau's training to accompany the roll out of the new Taser policy should be comprehensive and robust to ensure that officers have a firm and deep understanding of the legal and mechanical limitations of the Taser. (Report, p.97)*

26 *The Bureau should review its foot pursuit policy and consider whether it should expressly discuss the disadvantages of partner splitting, eliminate potential ambiguity on when armed suspects are to be pursued, and make mandatory radio communication at the initiation of a foot pursuit. (Report, p.100)*

27 *The Bureau should task its tactical specialists to develop safer and more effective ways to deal with uncooperative suspects who are seated in vehicles and to articulate these tactical principles in policy. (Report, p.101)*

28 *The Bureau should analyze relatively high speed PIT maneuvers to calculate estimated collision speed using all available tools. We further recommend that if these analyses show that PIT maneuver speeds within current permissible limits produce dangerous results, the speed parameter of the Bureau's current PIT policy be reassessed. (Report, p.104)*

29 *The Bureau should consider disallowing the box in maneuver where officers have a reasonable belief that the subject is armed with a firearm. (Report, p.104)*

30 *The Bureau should regularly assess the effectiveness of its Sergeant's Academy and Critical Incident Management training for field supervisors and consider whether they adequately instruct sergeants to maintain their supervisory perspective and avoid tactical involvement in incidents in which their officers are involved. The Bureau should hold accountable those supervisors who fail to adhere to these training standards. (Report, p.106)*

31 *The Bureau should consider whether to modify or eliminate the Commander's Memorandum as part of the review process for officer-involved shootings. (Report, p.107)*

Responses to the Report

CITY OF PORTLAND, OREGON

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

July 8, 2013

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

Dear Auditor Griffin-Valade:

I appreciate the opportunity to review and respond to the second report and recommendations from the OIR Group regarding Portland Police Bureau Officer-Involved Shootings. During the past several years, we have made changes to our policies, procedures, and training that we provide to our officers and supervisors. We have made changes in the way we investigate use of force and in-custody deaths, and continue to work toward streamlining the effectiveness and timeliness of our review process.

I would like to thank the OIR Group once again for their thorough and professional review of our officer-involved shooting investigations reviews. The Group continues to provide PPB with thoughtful and constructive recommendations as well as highlighting the challenges that critical incidents present to the men and women of a police bureau. I appreciate the Group's acknowledgement that PPB has made most of the recommended improvements on its own in the years following the reviewed incidents. I will implement those helpful recommendations that have not already been addressed.

We appreciate observations documented by the OIR Group in their previous report such as, "the PPB's ability to use critical incidents as a spring board toward systemic reforms has evolved over time. Its current use of exacting Training Division Analyses and a Police Review Board that includes peer officers and members of the public signify the Bureau's willingness to be self-critical in an effort to learn from its mistakes."

We remain committed to being transparent and we agree with OIR that there always will be room for enhancements or improvements. I look forward to working with the OIR staff and the Auditor's Office on all future reviews and assessments of the work we do for the City of Portland.

Sincerely,

Michael Reese

MICHAEL REESE
Chief of Police

MWR/tws

Portland Police Bureau Responses to OIR Group Report to the City of Portland
Portland Police Bureau Officer-Involved Shootings

Recommendation 1: The Bureau should review current protocols to determine whether they adequately ensure that officers in specialized units are receiving sufficient training regarding perishable skills necessary to perform patrol functions.

Agree. Current practice. Previously, the Training Division offered In-Service separately to our members twice a year, once for members assigned to the Operations Branch and once for members assigned to the Investigations Branch. While both In-Service trainings met the basic certification standards set by the state of Oregon, Operations Branch In-Service was geared toward patrol functions while Investigations Branch In-Service primarily catered to members in assignments outside the precincts.

The Training Division now offers a standardized annual In-Service training that all sworn members are required to attend. This training emphasizes skills necessary to safely and effectively perform patrol functions. This ensures that patrol function skills do not perish when members move to specialized assignments.

Recommendation 2: The Bureau should consider developing guidelines in its officer-involved shooting protocols to ensure that potential witnesses are not held at the scene for longer than necessary and that any circumstances surrounding a lengthy delay are documented in appropriate reports.

Agree. It is the current practice of the Police Bureau to ensure the rights of individuals are protected. PPB recognizes the legal requirements for the lawful detention of individuals and that it is usually unlawful to detain a person without probable cause or reasonable suspicion.

Recommendation 3: The Bureau should consider refining its Training Division Review protocols to ensure that the analyses include each involved officer's training record and adjudge the officers' performance based on the training provided to them up until the time of the incident.

Agree. Current practice. Last year, the Training Division instituted a new Officer-Involved Shooting Review Process SOP (#7-1) with specific steps and criteria to ensure the officer-involved shooting reviews created by Training staff accurately measure the involved member's performance against training received prior to the incident.

Recommendation 4: The Bureau should consider modifying its report writing materials to discourage referring to persons by their first names in police reports and to provide a standard method for distinguishing persons with the same surname.

Agree. In most cases, it is highly preferred to refer to individuals in police reports by their last names. The Police Bureau will provide additional training during the report writing classes to ensure members of the organization are provided this direction.

Recommendation 5: The Bureau should develop a procedure ensuring that an after-action report is created following arbitration findings to determine whether those findings call for systemic reform.

Agree. The Professional Standards Division will develop a Standard Operating Procedure, in consultation with the Office of City Attorney, instituting this level of review and Chief's Office referral procedures.

Recommendation 6: The City and the Bureau should consider devising written protocols to ensure that employees are notified of any intent to discipline them prior to notifying the general public.

Agree. Current practice. This is our current practice. However, the Bureau cannot prevent other bureaus, agencies or individuals from releasing information.

Recommendation 7: The Bureau should consider developing a written policy statement informing its members that the consequence of any violation of Bureau policy is a potential aggravating factor to be considered in determining the level of discipline to be imposed.

Agree. Current practice. Agree to pursue enhancements to current practice. DIR 335.00 DISCIPLINE PROCESS outlines the discipline process. The Directive lists a variety of factors to be considered in imposing discipline, including, but not limited to, the employee's intent, the potential harm to others or to the agency, and the seriousness of the performance deficiencies or misconduct. The Bureau will consider strengthening DIR 335.00.

Recommendation 8: The Bureau should consider revising its directive specifically informing its members that substandard performance and tactics can be a basis for imposing discipline.

Agree. DIR 335.00 DISCIPLINE PROCESS currently outlines the process, including a section titled Guidance for the Discipline Policy that addresses the basis for discipline. The Bureau has also added language to the draft force policy that requires members to use good decision making and sound tactics. Additionally, language in DIR 342.00 PERFORMANCE DEFICIENCIES will be reviewed to ensure similar changes are considered in the summary of job performance problems that may trigger a performance investigation.

Recommendation 9: The Bureau should revise its directives to expressly state that unsatisfactory performance issues in critical incidents may be significant enough to warrant severe levels of discipline without the usual prerequisite of previous progressive discipline.

Agree. DIR 335.00 DISCIPLINE PROCESS, the collective bargaining processes and labor law guide the Bureau's policy of progressive discipline. There is supplemental language in the directive that states: "Serious offenses include, but are not limited to, criminal or unlawful acts, abuse of authority, theft, untruthfulness, excessive force, failure to follow orders, unlawful discrimination, workplace harassment, retaliation, hostile work environment, or workplace violence and may justify suspension or discharge without the necessity of prior warnings or attempts at corrective discipline." The Bureau will consider adding: "performance issues relating to critical incidents" to the list of serious offenses.

Recommendation 10: The Bureau should implement its current draft policy setting forth the circumstances under which an officer may be relieved of duty or administratively transferred during the pendency of a critical incident investigation, including when the Chief has a reasonable basis to believe that the officer may be terminated.

Agree. The Portland Police Bureau created a "Draft" Standard Operating Procedure (SOP) on May 26, 2011. The draft includes language to address this recommendation. The Portland Police Bureau will review the document as it relates to the recommendation and implement as policy.

Recommendation 11: The Bureau should consider revising its shooting at moving vehicles policy to instruct its members that the policy is intended to cover a wider array of circumstances including the approach to stationary occupied vehicles that are likely to be put into motion.

Agree. In addition to the significant changes to its force, shooting at moving vehicles and entering vehicles policies and practices, PPB agrees to continue to look for enhancements that make the desired practice requirements very clear to arbitrators.

Recommendation 12: In termination cases involving multiple allegations, the Bureau should articulate which allegations, if any, individually supports its termination decision.

Agree. Current practice. Addressed in final discipline letters to employees**.**

Recommendation 13: The Bureau should ensure that command staff recognizes that it should be the overarching objective of every tactical engagement for the Bureau to dictate the outcome.

Agree. Current practice. It has long been the goal of PPB to control tactical scenes to the greatest extent possible. This goal is emphasized in tactical training at all levels. Officers, supervisors and command officers are trained to identify the clear legal standing and goal of a tactical incident, determine the necessary resources to accomplish the tactical goal, and to make a plan to accomplish the tactical goal on our terms with the least reliance on force possible.

However, it is the reality of many tactical situations that a subject *can* influence the course and outcome of the event.

Recommendation 14: The Bureau should ensure that its protocols on the handling of persons who die at the scene of a critical incident avoid contaminating the scene while maintaining the person's dignity by keeping them out of public purview.

Agree. Current practice. We are committed to maintaining the dignity of a deceased person while preserving the integrity of a crime scene. The supervisors from the Detective Division are responsible for providing training to new officers in the Advanced Academy, new sergeants in the Sergeant's Academy, and even new Fire Bureau supervisors on the need to preserve evidence at crime scenes. As a part of that training, we have instructed all members on the need to consult with the responding Detective Division supervisor prior to altering any crime scenes.

Recommendation 15: The Bureau should provide written guidance to its members that disfavors on duty handling of matters involving family members.

Agree. The Bureau will determine if language can be included in a current directive or does a new directive need to be created.

Recommendation 16: The Bureau should provide periodic briefings to field personnel regarding the placement of emergency equipment in patrol vehicles.

Agree. The Bureau will develop a process to accomplish this.

Recommendation 17: The Bureau should ensure that field personnel understand that its training curriculum and doctrine regarding the importance of crime scene management, the preservation of evidence and the integrity of the scene apply to officer-involved shooting scenes.

Agree. Current practice. The Police Bureau provides periodic training to officers and supervisors. In 2011, the Bureau presented a crime scene management class at the "Sergeants In-service" training. In 2012, a crime scene management class, which covered officer-involved shootings, was presented at the "Operations In-service" training. "Operations In-service" covers all uniform sergeants and officers.

Recommendation 18: The Bureau should continue to raise with the constituent agencies of the Major Crimes Team the issue of pre-interviewing officers involved in critical incidents and advocate for the adoption of its own consistent standard of avoiding unrecorded "pre-interviews."

Agree. It is the best practice to not conduct unrecorded pre-interviews with involved officers. PPB will continue to follow this best practice and encourage outside agencies to adopt it.

Recommendation 19: The City and Bureau should consider ways to formally bring BOEC supervisors or decision makers into the Police Review Board process in cases where a BOEC dispatcher's judgment or performance is potentially at issue.

Agree. PPB will consider ways to formally bring BOEC into the review process.

Recommendation 20: The Bureau should ensure that field personnel who may have occasion to use special equipment such as ballistic shields and gas canisters are trained on their availability and location.

Agree. Current practice. The Police Bureau deployed ballistic shields in the trunks of the majority of supervisor patrol units in 2010, and has trained all officers on their location and use at in-service. SERT has their own selection of ballistic shields that deploy with their equipment during all activations. Chemical agent capability is specialized and restricted to SERT and RRT. A selection of chemical agents (cold, warm, hot) and the launching equipment deploy with SERT on all activations. RRT does not deploy with chemical agents but does have access to and trains on the proper usage.

Recommendation 21: SERT training should emphasize that, in a barricade situation, it may be preferable to exhaust less dynamic and unpredictable tools –such as negotiation and K9s – before introducing gas.

Agree. Current practice. The existing threat to the public and police is weighed by the incident commander before authorizing SERT to engage in any action.

Recommendation 22: Investigation supervisors should ensure that adequate follow up is done by administrative investigators to obtain potentially relevant information from civilian witnesses.

Agree, with clarification. We understand this recommendation is not intended to imply that detective supervisors should manage Internal Affairs investigations. It is current practice that Internal Affairs supervisors ensure that adequate follow-up is done.

Recommendation 23: The Bureau should continue to employ sergeants in the field as critical members of specialized teams, but should also assess the role of these sergeants to ensure that they are acting like supervisors and not participating in operations as regular team members.

Agree. PPB understands that this recommendation is not a general criticism of PPB's recent experiment in teaming sergeants and patrol officers at times in some specialty units. PPB wishes to continue that experiment because it has resulted in significant reductions in use of force and complaints and has enhanced community policing. As for the concern that specialty unit sergeants working with a patrol partner may be drawn into operational roles in tactical situations, thereby losing their ability to provide supervision, PPB recognizes the potential problem and will

study the performance of its specialty unit sergeants and remedy any pattern of abdication of command.

Recommendation 24: The Bureau should consider revising its new ECW policy to strengthen and clarify the admonitions against the sustained use of the ECW.

Agree. The Bureau has new language in several sections of the proposed new ECW policy (1051.00) designed to address the issues of simultaneous and sustained use of the ECW. The proposed language is as follows:

Section 2.3 "Members will make an effort to handcuff and/or control the subject during and between ECW cycles."

Section 2.4 "Members should evaluate their force options and give consideration to other force options if an ECW is not effective after two cycles on the same person."

Section 3.9 "Members will not intentionally activate more than one ECW at a time against a subject if the initial deployment was effective".

The Bureau will review this language and determine if any additional language is needed to clarify the restrictions on the use of two or more ECW's as well as the sustained use of an ECW.

Recommendation 25: The Bureau's training to accompany the roll out of the new Taser policy should be comprehensive and robust to ensure that officers have a firm and deep understanding of the legal and mechanical limitations of the Taser.

Agree and implemented. During 2013 In-Service, the Taser Policy changes and content were instructed by Deputy City Attorneys in a classroom setting. Highly trained Taser Instructors taught the practical application of the changes. Two scenarios involving the use of the Taser were also used to measure officers understanding of the policy, practical application, and proper use.

Recommendation 26: The Bureau should review its foot pursuit policy and consider whether it should expressly discuss the disadvantages of partner splitting, eliminate potential ambiguity on when armed suspects are to be pursued, and make mandatory radio communication at the initiation of a foot pursuit.

Agree to review. Disagree on changes. PPB will continue to review the foot pursuit directive. Our current foot pursuit policy and training address the importance of broadcasting a foot pursuit. Officers also understand the importance of having additional resources to help apprehend a fleeing subject.

In all police work, there is a high priority placed on radio communication, but sometimes officers have to deal with immediate tactical situations that preclude radio communication.

Additionally, officers should not be restricted from pursuing armed suspects in every situation. There are times when the escape of a subject, or delay in apprehension, would present too high a risk to the safety of the community or other officers.

The potential hazards and disadvantages of partner splitting during foot pursuits are expressly discussed during Patrol Tactics training by our instructors.

Recommendation 27: The Bureau should task its tactical specialists to develop safer and more effective ways to deal with uncooperative suspects who are seated in vehicles and to articulate these tactical principles in policy.

Agree. PPB currently provides training on what OIR considers the best practices for dealing with uncooperative subjects seated in cars. We take from this recommendation that OIR is asking PPB to work with other agencies to develop the next generation of best practices in this area.

Recommendation 28: The Bureau should analyze relatively high speed PIT maneuvers to calculate estimated collision speed using all available tools. We further recommend that if these analyses show that PIT maneuver speeds within current permissible limits produce dangerous results, the speed parameter of the Bureau's current PIT policy be reassessed.

Agree. The current limits were set after extensive, nationwide experience, study and discussion. There is significant literature supporting the current limits. That said, PPB is dedicated to adding to the available data and will utilize its recently-developed vCAD and GPS technology to document the forces involved in future PIT events. In late 2011, PPB and BOEC completed a conversion to a new computer aided dispatch system (vCAD) which encompasses real time GPS in every patrol car.

In addition, every pursuit/ PIT is reviewed by several levels of PPB command staff as well as the Pursuit Review Board through Pursuit / PIT After-Action reports. A PIT that results in a serious accident with injury receives a full traffic crash investigation to include pulling data from both vehicles' "black boxes." PPB will make all this information and analysis available for internal and external review. In calendar year 2012, PPB utilized the PIT maneuver approximately 37 times.

Recommendation 29: The Bureau should consider disallowing the box in maneuver where officers have a reasonable belief that the subject is armed with a firearm.

Disagree. The box in maneuver is used by SERT when arresting potentially armed subjects who represent by their criminal history a serious threat to law enforcement and our community. In these situations, the box-in is often the tactic that allows the police to choose the place and time when the arrest is made in circumstances that best protect the community. The element of surprise and the ability to isolate a suspect and separate them from other persons or to prevent a potential barricade situation make this tactic an appropriate option.

The Bureau has also instructed patrol officers in the use of this tactic and cautioned them to use discretion in the application of the tactic given the specific threat. With proper training and

planning, the use of a box-in is an appropriate tactic when dealing with a potentially armed subject when other means of arrest may create a greater threat to the public.

Recommendation 30: The Bureau should regularly assess the effectiveness of its Sergeant's Academy and Critical Incident Management training for field supervisors and consider whether they adequately instruct sergeants to maintain their supervisory perspective and avoid tactical involvement in incidents in which their officers are involved. The Bureau should hold accountable those supervisors who fail to adhere to these training standards.

Agree. As a result of recent incidents, the Bureau has evaluated the effectiveness of the Sergeant Academy and Critical Incident Management training. The evaluation confirmed that the training does stress to sergeants that they need to take charge, lead and run tactical incidents they respond to. The training stresses the need for strong leadership on tactical calls.

The training specifically emphasizes that the role of a sergeant is to work through others (officers) to accomplish the goal of resolving tactical incidents toward the goal of maximizing the safety of all involved. The training recognizes that there may be times when sergeants need to become involved in the call by necessity, but sergeants are trained to return to the supervisory role as soon as possible. This training has been updated and revised as recently as 2011.

With respect to holding supervisors accountable who fail to adhere to these training standards, the Bureau has done this and will continue to hold its supervisors accountable to this critical training standard.

Recommendation 31: The Bureau should consider whether to modify or eliminate the Commander's Memorandum as part of the review process for officer-involved shootings.

Agree. Over the years, the Commander's Finding Memorandum has grown in both volume and complexity to ensure all issues are addressed. Up to this point, the memorandum has served us well and in many cases acts as an "executive summary." However, in our endeavor to reduce timelines, we will look to either modify or eliminate the memorandum.