Report to City of Portland

PORTLAND POLICE BUREAU OFFICER-INVOLVED SHOOTINGS AND IN-CUSTODY DEATHS

Seventh Report / April 2020

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Foreword

As we prepared this, OIR Group's Seventh Report on Portland Police Bureau officer-involved shootings and in-custody deaths, the Bureau was welcoming a new Chief and transitioning into the next phase of monitoring in its 2014 settlement agreement with the U.S. Department of Justice. That agreement stemmed from a Department of Justice finding that the Bureau had a pattern of using excessive force on individuals experiencing mental illness. The Department of Justice recently found the Bureau to be in substantial compliance with the terms of the agreement, which required the Bureau to make changes to the way it addressed mental health concerns but also resulted in significant adjustments to the Bureau's investigative protocols and internal review processes. The Department of Justice will continue to monitor the Bureau for at least the next year to ensure continued compliance.

Our work with the City and its Police Bureau continues to address many of these issues as they present in the context of officer-involved shootings and in-custody deaths. Adding the seven such critical incidents we review in this report to our prior work, we have examined a total of 57 officer-involved shootings and in-custody deaths involving the Police Bureau over the past 10 years. These critical incidents occurred over a 14-year span from March 2004 to November 2018 (all listed in a table attached as an Appendix to this report).

This report addresses seven incidents – six officer-involved shootings and one in-custody death. As with our prior reports, our review takes a deep dive into each of these critical incidents, to look at issues with communication and planning, tactical decision-making, efforts to de-escalate and make use of all available tools and equipment, and the effectiveness of supervisors to manage and direct resources and control the scene. Our review efforts focus heavily on the Bureau's internal investigations and multi-level review process to evaluate how well they identify concerns with officer decision making and performance that may fall

below Bureau expectation and standards and, more broadly, systemic issues that may affect future use of deadly force incidents.

We know from our years of working with Bureau leaders that the agency embraces the principle that sound tactical decision making both improves officer safety and reduces the likelihood of deadly force incidents. Its training, planning, and internal expectations reinforce this principle of progressive policing. While we have found instances where its review process has not universally reflected this emphasis, we also recognize the extent to which its investigative rigor and internal analyses of these incidents stands out among other agencies for their breadth, thoroughness, and willingness to derive lessons learned.

Of the seven cases we review here, as many as five involved subjects who had some history of mental health issues or were experiencing some type of mental health or addiction crisis. This is consistent with the pattern of cases we have seen over the years – 33 of the 57 officer-involved shootings and in-custody deaths we have reviewed in the past 10 years involved subjects who were apparently in some type of mental health crisis. This is not always easy to count precisely, because of a definitional problem of what it means to be "in mental health crisis."

If it is sometimes difficult to determine after-the-fact whether an individual's activity is an offshoot of a mental health concern, it can be even more challenging to discern in a moment of conflict. PPB officers are trained to take into account potential indicators of a mental health crisis to inform their actions and approach, but those indicators are not always clear, and sometimes there are competing needs to protect themselves and others. There are several examples of this dynamic in the incidents we report on here:

- One subject (Chase Peeples) had been acting irrationally in the hours leading up to his confrontation with police. One of the victims in an earlier crime even told police it was not clear that Peeples was trying to commit a robbery, and Peeples later told Behavioral Health Unit personnel that he had been pointing his wallet at people throughout the day. At the time they responded however, officers knew nothing about Mr. Peeples other than he was wanted on suspicion of bank robbery.

- Officers confronted another subject (Michael Grubbe) pointing a realistic-looking gun (later learned to be a BB gun) at them. They responded by shooting at him, and only learned three days later that he had a history of

mental illness that almost certainly impacted his behavior at the time of the officer-involved shooting.

- In another case, the subject (Sarah Brown) seemed delusional during the incident that resulted in her shooting, but officers who confronted her were understandably focused on the fact that she was pointing a gun and firing at them. Sound tactical principles necessitated deployment of the Special Emergency Reaction Team and crisis negotiators, regardless of any mental health concerns.

- And in the incident involving John Elifritz, all of the officers and many of the civilian witnesses remarked that Mr. Elifritz seemed to be under the influence of methamphetamine, an observation that was proven true by the post-mortem toxicology evaluation. Whether Mr. Elifritz had a dual diagnosis involving mental illness and drug addiction is not clear from the investigative record, but it was obvious to officers that he was in crisis, as evidenced by his erratic behavior and use of the knife to stab himself in the neck.

Over the course of the past 10 years, the Bureau's response to people in crisis has evolved considerably, beginning with reform efforts initiated following the death of James Chasse. The most significant evolution has come due in large part to the settlement agreement with the Department of Justice that required the Bureau and the City to devote significant resources to improving its systemic responses.

For example, the Bureau has created a Behavioral Health Unit that works to coordinate law enforcement and behavioral health system responses to assist people in crisis stemming from mental illness or drug and alcohol addiction. It has developed a cadre of Enhanced Crisis Intervention Team members who are dispatched to mental health crisis calls and who are available to respond to critical incidents when time permits. And all officers attend Mental Health Response training at the outset of their PPB tenure and during annual in-service training. The training emphasizes patience and observation, marshaling of specialized units and resources, and consideration of disengagement as a viable tactical option.

This training was in play in the officers' encounter with Mr. Elifritz, when earlier in the day they made the decision to disengage. Consistent with the Bureau's broader strategy of avoiding confrontation with people in mental health crisis after carefully weighing various risks, the involved officers and supervisors determined at that point that Mr. Elifritz posed no risk to himself or others and decided to leave him alone and refer him for future follow-up. That Mr. Elifritz's behavior escalated throughout the day to the point where he presented a

substantial risk of harm to others does not, in our view, undermine the Bureau's innovative approach to these complex issues.

Despite the substantial evolution in the Bureau's approach to mental health concerns, Portland police officers continue to use deadly force on people in crisis, leaving many to question how to make sense of the Department of Justice substantial compliance finding in conjunction with the number of people shot and killed by officers. We do not purport to have an answer to that question, but it is certainly related to a broader array of social concerns than just policing, including the availability of mental health and addiction treatment services, hospital practices, and poverty.

It also is true that the public tends not to see the Bureau's successes. For example, when police first encountered Mr. Elifritz earlier in the day that ended with his death, they made the decision to refer him to the Behavioral Health Unit rather than arrest him. They regularly make the same decision in similar circumstances, and the outcome is positive – an individual gets connected to mental health services with no further immediate law enforcement contacts – but those outcomes are not so visible to the public as is an officer-involved shooting. It is worth noting that many other agencies might have tried to take someone in similar circumstances into custody immediately, prompting a use of force and questions about its legal justification.

There are no easy answers to the very challenging questions around police encounters with individuals in mental health or addiction-related crises. Perhaps the best response police agencies can provide, as we have noted in other contexts, is to build a reservoir of goodwill through honest dialogue, receptivity to feedback, transparency, and a demonstrable willingness to evolve and improve.

The advancements the Bureau made while working toward compliance with the Department of Justice settlement agreement, including the creation of new teams, strategies, and training protocols, are a good step toward building this goodwill. Efforts the recently-departed Chief made toward community outreach following an officer-involved shooting or controversial incident, including the routine release of detailed information, meeting with family members, and convening community meetings, also are critical to advancing the type of dialogue and transparency needed.

Of course, neither directed training efforts nor improved outreach and communication efforts preclude the possibility of future critical incidents

involving people in crisis. They can, however, enhance confidence in the legitimacy of the Bureau's responses.

As with past reports, we consider it our responsibility to credit the Bureau when we observe quality investigative and review practices, and to point out those instances when we do not. Our overarching objective remains the facilitation of continued improvement to protocols that already exceed industry standards. Accordingly, and as detailed in the body of our Report, we were disappointed that problems with timely completion of the investigative and review process are ongoing. We were pleased that involved officers were being interviewed closer in time to the incident, but we nonetheless strongly advocate an interview protocol where officers are interviewed before they are sent home. We were concerned that critical non-Bureau witnesses working for the City or a public university ignored or defied requests for their accounts despite the existence of subpoenas created to ensure their cooperation. And we were troubled when members of the Behavioral Health Unit were used as an investigative arm of Detectives when they visited the person shot while he was in the hospital.

On the incident review side, we were disappointed when two of seven commanders failed to write a substantive analysis of fatal shootings, discouraged when a Training Division Review did not engage in any analysis or identify any issue worthy of reflection, and disquieted when we learned that in three cases Training staff stepped out of their lanes and vouched in the grand jury for the appropriateness of involved officers' use of deadly force with only a passing familiarity of the facts. And we worry when we see the application of the "action/reaction principle" as a reflexive justification for the officers' use of deadly force, in a way that recalls how the reference to "furtive movements" was uncritically used in the past to justify officers' actions.

We expect that, as in the past, the Bureau's leadership will continue to consider our observations and recommendations in the spirit in which they were made: not to criticize for criticism's sake but to foster dialogue with an eye toward refinement of investigative and review protocols. We look forward to that dialogue with the Bureau and its community in conjunction with the issuance of this Report.

We have reviewed critical incidents in Portland for nearly a decade, and during that time have appreciated the unwavering degree of cooperation from Bureau

members – from the Chief's office, through the entire executive staff, to Captains and Lieutenants, to Sergeants and Officers – who have been uniformly candid, helpful, and generous with their time. They have provided us documents when we needed them, responded to phone calls and emails quickly and substantively, opened their offices for meetings and training facilities for observation, and been willing to engage with us in meaningful discussions about Bureau practices, training, national best practices, and a host of other subjects relevant to our work. While we do not always agree on significant issues and are often pointedly critical of Bureau actions or practices, our dialogue with Bureau members has always been constructive and respectful. That is not a statement we can make about every law enforcement agency with which we have worked, and we appreciate the relationship we have been able to build with the Bureau.

It is also important to recognize the support, insight, and perspective we continue to receive from the Auditor, the Independent Police Review Director and staff, and the Mayor and Commissioners. Each has been gracious with their time, and have contributed to our work by strengthening our knowledge of the interrelationships between the Bureau and other City functions. Finally, the level of engagement and discourse from Portland's public in connection with our presentations also provides critical perspective from those directly impacted by the actions of the Police Bureau and we appreciate that dialogue and insight.

Scope of Review

With this report, we have examined all officer-involved shootings and in-custody deaths for which the investigation and administrative review was complete by the July 1, 2019. As we have done for each of our prior reports, we reviewed all of the Bureau's investigative materials for each of the seven critical incidents we evaluate here, including the Detectives' and Internal Affairs' investigations, as well as grand jury transcripts where available. We also read and considered the Training Division Review and materials documenting the Bureau's internal review and decision-making process connected with each incident. We requested, received, and reviewed relevant training materials, referred back to training materials we reviewed for our prior reports, and spoke with current Training Division personnel. We talked with Bureau executives regarding questions that were not answered in the initial materials provided and requested additional documents that were responsive to those questions.

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 focus on whether any particular shooting, or related tactic or use of force, is within policy, but do point out where we see officer performance that appears to be inconsistent with Bureau directives and expectations. We also identify issues that were not identified, addressed or thoroughly examined 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 or resulted in a lost opportunity for remediation or improvement.

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SECTION ONE

Officer-Involved Shootings

Summary and Analysis

May 28, 2017 ◦ Michael Grubbe

At about 6:30 in the morning, a motorist in a residential neighborhood of Portland saw a man walking down the sidewalk with a gun held in both hands pointing downward. The motorist called 911, and Portland Police officers were dispatched to the area. The first officer on the scene, Officer Matthew Jacobsen, saw a subject – later identified as Michael Grubbe – walking on the sidewalk who fit the dispatch description of a white male in his 40s with a backpack. Officer Jacobsen parked his patrol vehicle across the street and could see that the man did not have a gun in his hands. He had just gotten an update from dispatch that the subject had put the weapon in his pocket.

Officer Jacobsen was aware that other officers were en route and remained in his patrol vehicle. He observed the subject on the other side of the street walk behind some shrubs and then reappear walking in the same direction. The officer became more apprehensive as he observed Mr. Grubbe staring at him steadily as he walked. He got out of his vehicle with his Bureau-issued shotgun and, while keeping the vehicle between Mr. Grubbe and himself, identified himself as a

police officer and called to Mr. Grubbe to show his hands. Grubbe made no response, then began to lift his shirt. Officer Jacobsen yelled "Stop. Show me your hands," in a voice he described as "now loud, very command presence and mean." Grubbe pulled a pistol out of his waistband and pointed it at the officer.

Jacobsen later recalled repeating his commands several times and then firing about three buckshot rounds from his shotgun at Grubbe, who now was pointing the pistol at him with both hands. The back stop behind Grubbe appeared to be tall embankment below a house, about 25 feet away from Jacobsen and across a narrow street. Mr. Grubbe did not appear to Officer Jacobsen to react in any way to either the commands or the shots. Jacobsen, who was looking across the front hood section of his patrol SUV, moved toward the middle of the vehicle for additional cover from the structural pillar between the front and back door areas. He then reloaded his shotgun with "slugs" (large bullets rather than buckshot) and watched Grubbe walk away northward.

Officer Matthew Brown arrived on scene while Mr. Grubbe was still visible walking away. He approached Officer Jacobsen, who asked him to drive Jacobsen's SUV – which was equipped with more protective ballistic door panels – slowly in the direction Grubbe was walking. Jacobsen and Officer Sara Fox, who arrived a few seconds later, both walked along with the SUV, staying near the open driver's door. Officers Brown and Fox had heard the sound of the first shots fired by Jacobsen just before their arrival.

Very shortly, the three officers, moving together, reached the next corner. Mr. Grubbe, still ahead of them, walked out of sight around a bend about a block to the north. The officers could hear that other officers were arriving on the perimeter that was being established and managed by supervisors over the police radio system. The officers decided to park and pursue no further, but instead to maintain their position at the corner where they had stopped their SUV.

Several minutes later, Officer Brown saw a man walking nearby from another direction who "looked like he was trying not to be noticed." He asked Officer Jacobsen, "Is that the guy?" Jacobsen answered "yes" and the two officers yelled orders at Mr. Grubbe to drop the gun and show his hands. He then observed Grubbe walking eastbound toward the corner near them. Apparently having circled the block, Grubbe passed behind a boat on a trailer hitched to an SUV parked against the sidewalk and ducked down behind it. Jacobsen saw the gun in Grubbe's hands again and yelled at him to show his hands and drop the gun. When Grubbe did not comply or respond, Jacobsen aimed his shotgun at Grubbe,

who was an estimated 25 to 35 yards away and partially obscured by the boat, and fired a round. Jacobsen later stated that he could see that Grubbe was pointing "the gun at us." He saw Grubbe pull back then return to a position of pointing the gun again. Jacobsen fired again. He saw Grubbe throw the gun down on the pavement beneath the boat trailer and begin to walk away swiftly. That Grubbe had apparently discarded a gun was broadcast to other officers.

Officer Fox had also perceived that Mr. Grubbe was pointing his gun at her, and she fired three rounds from her service pistol at him until he moved back behind the boat. Fox then saw him "pop back out again" on the other end of the boat, this time crouching down "with the gun pointing directly at us." At that point, Officer Jacobsen crouched low to aim his shotgun directly beneath where Fox was crouched so she decided to stop firing, so as not to endanger Jacobsen.

Meanwhile, Officer Brown had seen Mr. Grubbe, "army-crawling" behind the boat and crouched down himself in response. He then heard what he thought was an "exchange" of gunfire and fired his own shotgun six times at what he could see of Grubbe between the boat and the ground. He and Officer Fox then heard the sound of Grubbe's gun on the pavement and saw Grubbe depart, running with a limp.

During this second confrontation with Mr. Grubbe, a nearby resident, looking from his second-floor balcony, saw a man crouching behind the boat. He heard Grubbe yell, "I don't have a gun," to the officers across the street. He could see that the man was indeed holding a gun in both hands pointed toward the officers, so he warned the officers that "the man [is] behind the boat and has a gun." The officers had heard Grubbe claim to have no gun, heard the resident on his balcony, and continued to yell, "show us your hands, show us your hands" at Grubbe. After the officers fired, the resident saw the man run with a slight limp headed northward and out of sight.

As Mr. Grubbe moved away, he appeared to Officers Jacobsen and Fox to have empty hands. Jacobsen and his partners remained in place and watched Grubbe disappear around the corner a block away. Officer Brown called to request that Bureau's Special Emergency Reaction Team (SERT) provide assistance at the scene.

Other officers who arrived at the scene just before or at the time of this second shooting saw or heard Mr. Grubbe throw his gun down on the pavement and run northward up the street with nothing in his hands. They too chose not to pursue him because they were not sure if he had another weapon. A short time later,

assisting officers recovered the discarded gun under the boat. It turned out to be a BB gun designed to look exactly like a semi-automatic pistol.

SERT arrived at the scene after the second shooting and replaced the patrol officers on the perimeter. They searched the area but did not find Mr. Grubbe. Hours later that afternoon, when the containment efforts were still in place, officers on the perimeter were alerted to reports of a man meeting Mr. Grubbe's description at a location outside the perimeter about eleven blocks from the second shooting site. They located Grubbe and arrested him without incident.

During the entire incident, Officer Jacobsen fired his Bureau-issued shotgun three times with buckshot and three times with shotgun slugs. Officer Fox fired her Bureau-issued handgun three times. Officer Brown fired buckshot rounds from his Bureau-issued shotgun six times. Michael Grubbe did not fire his BB gun and was not struck by the gunfire from the three officers.

Following his arrest, Mr. Grubbe was not charged with a crime because prosecutors determined that he could only be charged with a misdemeanor, "menacing," and that he would be released soon anyway. On May 31, 2017, three days after the officer-involved shooting, Portland Police Bureau officers responded to a burglary report called in by Mr. Grubbe's mother. She said that her son had tried to get into the house, that she and other family members had refused to let him in, and that he had a history of mental health issues.

Officers searched the mother's neighborhood and found Mr. Grubbe on a nearby corner carrying a metal pipe in his hand, but he dropped it after repeated commands by officers. Two officers overtook him from behind, took him to the ground, and handcuffed him without injury or further use of force.

The Bureau informed the County's Community Mental Health Director of Mr. Grubbe's recent encounters with officers. She concluded that he was a danger to himself and others and in need of immediate care for mental illness and she approved his detention for three days at a mental health facility, pending evaluation of the need for a longer period of treatment.

The District Attorney's Office declined to conduct a grand jury review of the police use of deadly force because there had been no injury to Mr. Grubbe.

The Training Division Review found the actions of the involved officers to be consistent with policy and training but recommended remedial shotgun training for Officer Jacobsen because of his aiming deficiencies. They also determined

that the initial supervisor on the scene, Sergeant James Mooney, should have gotten a more thorough briefing on the facts before taking decisive control of the incident. A minority of the voting members of the Police Review Board later agreed with this position. Conversely, the Unit Commander felt that the sergeant's actions were reasonable and consistent with Bureau practice and culture. The Commander found that the use of lethal force was reasonable under the circumstances. The Police Review Board determined that the performance of all the involved officers and their supervisors was satisfactory but recommended that "all involved officers and sergeants participate in an incident debrief to review roles and procedures as a learning opportunity." The Chief agreed that all actions by involved officers and supervisors were in policy, but she did not order any formal debriefings.[1]

Timeline of Investigation and Review

5/28/2017	Date of Incident
6/26/2017	District Attorney Prosecution Decline
10/5/17	Internal Affairs Investigation completed
9/22/2017	Training Division Review completed
11/5/2017	Commander's Findings completed
1/10/2018	Police Review Board
1/25/2018	Case Closed

[1] Approximately a month after the incident, Officer Jacobsen voluntarily requested and received additional training to improve his aim and handling of the shotgun.

OIR Group Analysis

Use of Deadly Force

Mr. Grubbe pointed what gave every appearance of being a gun at officers and they shot at him with shotguns and a handgun. Mr. Grubbe was not wounded.

Each decision by a police officer to fire a gun engages a series of risks and trade-offs. These include the risk to nearby officers and civilians posed by off-target bullets fired by the officers or by the suspect. In this case, the off-target risk was illustrated vividly by twenty-six shotgun pellets that struck, and in some instances, entered the front door and surrounding walls of the house behind Mr. Grubbe when Officer Jacobsen first fired his shotgun at him.

Officer Jacobsen's perceptions of his aiming back stop at the first location were significantly inaccurate, and this greatly affected the off-target problem. The grassy berm behind the sidewalk where Mr. Grubbe was standing when Officer Jacobsen saw him first point the weapon at him was a maximum of five feet high – not the twelve to fifteen feet high that the officer believed and described in his interview. The officer stated that he was conscious at the time that his shotgun could be difficult to aim and that he had to pay special attention to the aiming process. He nevertheless fired at least one shot high of the suspect and hit the middle area of the front door of the house that sat on top of the berm.

The Training Division, in its written analysis of the incident, called attention to this as both an operator error (poor aim) and a result of a poorly designed or obsolete aiming site on the Bureau's current shotgun. Good equipment is vital, especially when it relates to lethal force, and Training's recommendation to reevaluate and modify or replace the shotguns is commendable.[2] But Training did not mention the officer's significant misperception of the back stop. Stress is an acknowledged factor that influences effective aim in a real encounter, but stress is

[2] Two years after Training called attention to the shotgun issue, their recommendation is soon to bear fruit. The Bureau's armory staff has purchased new shotguns with simpler sight systems that they believe will be more effective in the field. Perhaps more significantly, Training has developed a course and certification process focused on the shotgun and modeled on the certification standards for the AR-15 rifle within the Bureau. If implemented, this will recognize that the shotgun is a distinctive firearm requiring officers to develop specialized skills.

not immutable. It is specifically addressed in many types of firearms training for peace officers. Officer Jacobsen was required to complete remedial training in the use of the shotgun, but as far as we know, that training did not address the misperception of back stop under stress.

> RECOMMENDATION 1: The Bureau should routinely refer officers for firearms training that includes stress recognition and reduction after any incident involving firearms use that indicates misperception of target or surroundings.

Mental Health Concerns

After Mr. Grubbe's arrest on May 28, he was released without charge. He was arrested three days later when his mother reported that he was attempting to break into her house. After that, he was taken into custody and transported to a mental health facility for evaluation and possible further treatment.[3]

This appropriate use of Oregon law and the available mental health evaluation and treatment network raises the question of why this approach was only applied after Mr. Grubbe's second arrest three days after the shooting incident, especially since the shooting incident was cited by the Mental Health Director as the main reason for the mental health detention. Mr. Grubbe had a long history of arrests and outstanding warrants and had demonstrated during the shooting incident that he was a "danger to himself or others," yet he was released.

The Bureau should consider how it can streamline its interaction with the City and County mental health infrastructure in order to avoid unexpected releases that are a setback for the health of the subject and community safety.

> RECOMMENDATION 2: The Bureau should meet with leadership from the District Attorney's Office and the Community Mental Health Director to explore compassionate solutions to the problem of arrested persons who will be released without charge but are determined to be in mental health crisis and in need of further evaluation and/or treatment.

[3] Oregon laws allow law enforcement to do this with the approval of the Community Mental Health Director. ORS 426.333 et seq.

Supervision and Communication

The three initial officers at the scene communicated their positions, observations and actions in a clear and timely manner, yet some later arriving officers and supervisors nonetheless drove into the center of an active shooting scene, potentially endangering themselves and disturbing evidence such as shotgun shells and bullet casings.

The perimeter was set up quickly, yet the suspect seems to have slipped through it. The Bureau did not determine why Mr. Grubbe eluded the containment perimeter after the shooting incident, in part because Grubbe was not able to provide useful information after his arrest later that afternoon. All of the supervisors were given a positive evaluation for assuming and sharing their appropriate duties as they arrived at the scene.

Containment is neither an exact science nor a guarantee of apprehension. But in a case of this type, where the suspect is believed to be armed and aggressive, it is important to evaluate the reasons – including potentially correctable ones – why the containment efforts did not work. While the Training Division discussed some deficiencies in the organization and burden sharing by sergeants as they arrived at the scene, their analysis did not address the fact that the Bureau's containment strategy was not successful. When reviewing critical incidents, the Bureau should perform a detailed analysis of any tactical decision-making surrounding the event.

> RECOMMENDATION 3: During critical incident reviews, whenever a Bureau-initiated tactic or frequently-used technique does not produce the desired results (such as when a subject escapes from a containment perimeter), the Bureau should conduct an analysis with the objective of improving those tactics and techniques in future incidents.

Timeliness of Interviews and Investigation

The Internal Affairs investigators did not interview the involved officers and most of the supervisors until 25 days after the incident.[4] Such long delays can mean

[4] This incident occurred during a time of uncertainty in how the Bureau should proceed with officer interviews following critical incidents. Council had done away with the so-called "48-hour rule" in the Portland Police Association contract, followed by the District Attorney's office weighing in with its concerns about administrative investigations potentially

that the Bureau is without detailed first-hand knowledge of the incident while proceeding with internal investigations and preparing to present a case to the District Attorney. This level of delay is fortunately no longer a common practice of the Bureau, but even a short delay greatly increases the likelihood that an involved officer will be exposed to degraded memory and/or outside information that can further compromise accurate recall. For these reasons, as we discuss further below, we advocate that the involved officers be interviewed soon after the incident and before they end their shift.

The investigation of this incident was not completed until more than two months beyond the 180-day time limit agreed to by the City and the Department of Justice.

compromising criminal investigations, and prior to Council's subsequent vote to affirm that officers must be interviewed within 48 hours of an incident. That vote occurred on August 23, 2017 with directives implementing Council's determination on September 27, 2017.

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August 30, 2017 ◦ Jesse Brockner

Shortly after noon August 30, 2017, a PPB Detective assigned to the Robbery Detail received a request from his partners on an FBI Task Force to assist with the investigation of a bank robbery that had occurred at around 9:30 that morning. The FBI had identified the suspect as Jesse Brockner, and had information that he was driving a distinctively-colored Chevy Blazer with a lifted suspension. He was reported to be carrying a handgun, which he had pointed at the bank teller during the robbery.

The Detective was on his way to an address associated with Mr. Brockner when he spotted the Blazer and then confirmed the driver was the robbery suspect, based on description and visible tattoos. The Detective's Task Force partners requested that PPB conduct a stop. He continued to follow the vehicle in his unmarked undercover car while calling for backup.

Two patrol officers responded and began following the subject, while the Detective dropped back behind them. Officer David Staab took up the position directly behind the subject, who appeared to recognize the presence of a marked patrol car immediately and accelerated quickly. After Mr. Brockner sped away, Officer Staab activated his overhead lights and siren and initiated a pursuit. The pursuit lasted around one minute and 45 seconds and reached speeds of approximately 50-55 miles per hour on mostly residential streets before Brockner crashed into an unoccupied parked car and stopped his vehicle.[5]

Officer Staab stopped his patrol car behind the Blazer, at a slight angle,[6] and quickly got out to run toward the Blazer. This was, in part because he could not see the driver from his position at his own car,[7] and in part because he anticipated that the driver would bail out and flee on foot. When Brockner's door remained

[5] At one point during the pursuit, Mr. Brockner sideswiped a parked vehicle as he turned a corner, but that did not noticeably slow him down.

[6] Training for high-risk felony stops instructs officers to stop in a position that offsets the subject vehicle and provides the officer with a view of the subject. Officer Staab acknowledged this, but his positioning was limited by parked cars on the opposite side of a very narrow street.

[7] The height of the "jacked-up" Blazer and the positioning of Officer Staab's car contributed to the inability to see inside the subject's vehicle.

closed, the officer moved toward a position of partial cover/concealment behind a tree that was across the street on the driver's side of the subject's Blazer and about 12-15 feet away. The officer then began shouting commands for the subject to show his hands. Though both other officer and civilian witnesses say the officer was shouting very loudly, and there could be no doubt the subject could hear him and recognize his status as a police officer, his hands remained out of view and the officer reported he showed no sign of attempted compliance with the officer's increasingly urgent and profanity-laced commands and warnings.

Mr. Brockner looked at Officer Staab at least twice, which caused the officer to conclude that he had not been incapacitated in the collision. Then the subject made what Staab described as a deliberate move forward, as if he was reaching for something or trying to manipulate the vehicle in some way to get it moving again. Staab believed at this point he had "no choice" other than to fire at Brockner, based on his knowledge that he had earlier used a gun in a robbery and his deliberate disregard of the officer's orders.

Officer Staab fired three times, shattering the driver's window and striking Mr. Brockner in the neck, in what turned out to be a superficial through-and-through wound. A second bullet lodged in the door frame, and the third passed through the vehicle and into the front porch railing of a home. Fewer than 15 seconds passed between the time the vehicle was reported to have crashed and Staab's gunfire.

Mr. Brockner then began responding to the officer's orders to show his hands and eventually to exit the Blazer with his hands up. At this point, the second patrol officer was at the scene, along with the Detective and a supervising sergeant, who arrived just after shots were fired. They relieved Officer Staab and worked together to handcuff Brockner, then quickly provided medical aid, packing the wound with specialized gauze meant to speed up blood clotting and stop bleeding. Paramedics arrived shortly after the shooting and transported Brockner to the hospital, where he was treated and then released to custody.

FBI agents later searched the Blazer and found a loaded handgun on the floor of the vehicle.

The District Attorney's Office decided against presenting this shooting to the grand jury, citing its discretionary policy and finding that a grand jury review of this case was unwarranted because there was a clear legal basis for the use of deadly force. The Police Review Board found all aspects of the incident to be within policy, but recommended a formal debriefing and performance analysis

with Officer Staab concerning tactical and communications issues. The Chief agreed with the Board's recommendations.

Timeline of Investigation and Review

8/30/2017	Date of Incident
10/18/2017	Internal Affairs Investigation completed
10/23/2017	District Attorney Prosecution Decline Memo
12/15/2017	Training Division Review completed
2/20/2018	Commander's Findings completed
4/9/2018	Police Review Board
8/7/2018	Case Closed

OIR Group Analysis

Vehicle Pursuit

The investigation and review thoroughly examined the vehicle pursuit that preceded the shooting. Officers knew they were pursuing a suspect in an armed robbery, a felony that clearly met criteria for authorization in the vehicle pursuit directive. The undercover Detective driving the unmarked vehicle appropriately yielded to officers in marked patrol cars and essentially removed himself from efforts to apprehend the subject. He continued to follow and monitor the activity, but was cognizant of the risks and limitations presented by his undercover status and remained in a support role. Communication with the Bureau of Emergency Communications was clear and provided regular updates on the speed and direction of travel. Interviews of all the officers involved in the pursuit demonstrated their awareness of environmental and traffic conditions, the presence of pedestrians, and other relevant factors listed in the pursuit policy.

Also, a sergeant was monitoring the pursuit and planning where to position spike strips if the subject had continued to flee.

All of these factors were examined in the Internal Affairs investigation and analyzed by Training, the Commander and the Police Review Board. It has become standard practice in Portland to review vehicle pursuits as part of a holistic review of an officer-involved shooting, but it is nonetheless worth noting and commending.

Tactics and Communication

The pursuit ended quickly, when the subject crashed into a parked car. Officer Staab almost immediately got out of his patrol car, ran toward the subject's vehicle and then to a position behind a tree, shouted commands at Mr. Brockner, and then fired his weapon three times. This all occurred within 15 seconds of the crash that terminated the pursuit.

The Training Division Review examined each of these actions, step-by-step, taking into account Officer Staab's interview responses about his thought process and decision making at each point. Training determined that the officer's tactics prior to the shooting were "not consistent with training or create[d] an unnecessary or serious risk."[8] The analysis focused on Staab's decision to so quickly leave his position of cover behind his own car door to get closer to the subject he believed to be armed, and to do so without a tactical plan and without communicating with the other officers in the pursuit and on scene.

The Commander's Review and Findings Memorandum tracked the points made by the Training Division, but ultimately concluded that all of Officer Staab's actions were within policy. While the Commander acknowledged Training's concerns about the officer's quick movements, he gave greater weight to the officer's statement that he needed to move from his patrol car to gain a better view of the subject in the Blazer. Nonetheless, he recommended the "in policy" finding to be accompanied by a formal debriefing and performance analysis. The Police Review Board adopted the Commander's findings and conclusions.

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[8] For its analyses, the Training Division employs a rating scale that includes:

1. Actions are not consistent with training or create an unnecessary or serious risk.
2. Actions generally acceptable but create identifiable risks.
3. Actions are consistent with training, but are not the most effective method or tactic.
4. Actions demonstrate sound and effective tactics.

The formal debriefing with the officer included a Patrol Tactics Instructor from Training as well as the Commander and covered a range of subjects relating to the officer's actions and tactical considerations, including his positioning during this incident and the dangers of a potential foot pursuit.

Use of Deadly Force

The Training Division Review found the officer's use of deadly force to be "generally acceptable" but nonetheless created "identifiable risks." This conclusion focused not so much on the shooting but on the fact that Officer Staab did not advise other officers that he had fired his weapon or about the status of the subject. The second officer in the pursuit broadcast that shots had been fired, but he did not know by whom, creating momentary confusion over dispatch about whether Staab had been shot.

The concerns raised by Training about the officer's communication certainly were significant. Even though a second officer was right behind him during the pursuit, Officer Staab rushed ahead unilaterally without making any contact with his backup, and then did not communicate any updates after shots were fired.

About the decision to use deadly force, however, the Training analysis restated without scrutiny the officer's articulation – his understanding that the subject in the truck was definitely Brockner, and that awareness that the man had recently used a handgun to commit a bank robbery, ignored the officer's commands, and reached forward to the floor of the vehicle. The analysis would have benefited from further examination of this decision-making, especially in conjunction with concerns about communications. For example, if the officer had coordinated with backup, was there an opportunity to take a different approach with the subject? And while Brockner certainly presented a high level of risk, given the likely possession of a gun and earlier willingness to threaten someone by pointing it, how should the availability of at least minimal cover impact the threat assessment in these circumstances?

Training also gave minimal scrutiny to potential questions about Officer Staab's back stop, which included a house. Training notes that the officer correctly identified the back stop, but does not address the implications of the officer's statement that the fact he was shooting toward a house did not affect his decision-making. How should that factor – or the fact that Staab said he was not aware where his fellow officers were at the time of the shooting – have weighed in the threat assessment and decision to fire?

While the answers to such questions may not have changed the relevant conclusions, a more rigorous engagement with them would have enhanced the review process.

Use of Profanity

Officer Staab stated that the commands he repeatedly shouted at Mr. Brockner included, "Put your fucking hands up," and "I'm going to shoot you in the fucking head if you don't put your hands up." The use of profanity by law enforcement in situations such as this is nothing new or necessarily surprising. We have heard frequent arguments that this kind of language is a verbal tactic meant to gain a subject's attention and emphasize a degree of urgency in the midst of confrontation.

Nonetheless, the Bureau's directive on Professional Conduct and Courtesy generally prohibits the use of profanity, and states that its use "will be judged on the totality of the circumstances" in which it arises. Unfortunately, Internal Affairs investigators did not question the officer about his word choice. Nor did any of the Bureau's reviewers – Training, Unit Commander, or Police Review Board – even mention the officer's language, which he clearly and openly acknowledged in his Internal Affairs interview. Failure to even engage in an analysis of the surrounding circumstances *assumes* that the officer strategically or tactically used this language, and overlooks that very real possibility that the language stemmed instead from factors such as heightened anxiety, frustration, or loss of temper – all of which the relevant directive is presumably intended to limit. Ignoring the issue completely sends a message to officers that the Bureau does not consider the policy applicable in the context of a critical incident. This is not an approach we advocate, especially given the loss of control that neutral observers can read into such language.

> RECOMMENDATION 4: The Bureau's review process should examine an officer's use of profanity when confronting a subject, assess the totality of the circumstances, and determine whether the language used was consistent with the Bureau's expectations.

Consideration of Alternative Scenarios

Officer Staab said in his Internal Affairs interview that once Mr. Brockner leaned forward, after disregarding the officer's commands and warnings, "I have no choice" other than to shoot. In our Sixth Report, we wrote about the downsides of concluding that a given outcome is preordained or inevitable and recommended that Training avoid using language that suggests officers had no options other than the use of deadly force. There are, we noted, always alternative scenarios worth considering. The Bureau agreed with this assessment. We are pleased that none of the Bureau's reviewers here adopted or endorsed the officer's "no choice" language, but also note there is no record that Staab was counseled about his mindset that the situation presented him with no option beyond firing his weapon.

Timing of Interviews and Statements

Internal Affairs investigators interviewed Officer Staab two days after the shooting (a significant improvement over prior bureau practice, but not sufficiently close in time to the event to be considered ideal). Because this was a compelled administrative interview, it could not be disclosed to or used by the Detectives conducting the criminal investigation, nor the District Attorney's office in assessing potential criminal charges against the officer.

Homicide Detectives interviewed the witness officer and detective on the day of the shooting. But, as has become the practice among Bureau members, the shooting officer declined to give a voluntary statement to Detectives. Typically, the shooting officer participates in the criminal investigation by testifying to the grand jury about his or her actions and state of mind. Here, because the District Attorney decided against presenting this incident to the grand jury, there was no testimony from Officer Staab included in the criminal investigation. This presented a problem for the FBI and the Assistant U.S. Attorney prosecuting Mr. Brockner for the bank robbery, so Staab prepared a written voluntary statement a month and a half after the incident. The District Attorney cited this statement in its October 23, 2017 Prosecution Decline Memo.

Timeliness of Investigation

The Bureau finished its investigation and reviews by Training and the Commander in 174 days, but then took extra time to get the matter to the Police Review Board, which heard the case 222 days after the shooting. Then the Chief

did not sign off and close the case for another four months (342 after the incident, well off the 180-day mark set in the Bureau's agreement with the Justice Department). Given the ongoing scrutiny of these timing issues, the Bureau must do better, particularly when the delay seems to be purely administrative.

October 25, 2017 ◦ Chase Peeples

Officers Ryan Reagan and his partner[9] were on patrol when information about a bank robbery was relayed to them. There was no indication that a firearm was used or displayed during the robbery. The officers soon came upon an individual on foot, later identified as Chase Peeples, who fit the description of the bank robbery suspect. Officer Reagan stated that he stopped the patrol car approximately 60-70 feet from the individual, got out, placed himself behind the driver's door, and instructed the person to show his hands. Reagan said that instead, Mr. Peeples withdrew a black object from his pocket that appeared to be a handgun, assumed a "shooting stance," and pointed the object at the officers. Reagan fired six shots at the subject, with three of the rounds striking Peeples in the upper right arm, right foot, and lower left abdomen.

The partner officer said when the patrol car stopped, he got out, placed himself behind the passenger door and observed Officer Reagan give commands. The partner officer said that instead of complying, the individual placed his hand into his pocket and began to withdraw it. The partner officer said he would have used deadly force at that point, but his view was obstructed by a light pole, so he moved to the back of the car and ran toward Reagan. The partner said that he heard gunshots and saw the individual go down.

Mr. Peeples was taken into custody and transported to the hospital. Peeples survived his wounds and was released from the hospital several weeks later. The scene investigation revealed Peeples' wallet nearby but no firearm. Peeples eventually pleaded guilty to robbing the bank and attempting a robbery of a check cashing store minutes before.

The District Attorney presented this case to the grand jury, which concluded the use of deadly force by Officer Reagan was legally justified. The Police Review

[9] When preparing reports for the City of Portland, OIR Group practice has been to publish the names of any Bureau members deemed "involved" or "reviewed" by administrative investigators. Because Officer Reagan's partner neither fired his weapon nor had any other aspect of his performance formally reviewed as part of the administrative investigation, we do not reference the partner's name.

Board found that the shooting was within policy and that all post-incident procedures were appropriate.

Timeline of Investigation and Review

10/25/2017	Date of Incident
12/6/2017	Internal Affairs Investigation completed
12/13/2017	Grand Jury completed
3/21/2018	Training Division Review completed
4/2/2018	Commander's Findings completed
5/30/2018	Police Review Board
6/21/2018	Case Closed

OIR Group Analysis

Tactical Issues

Failure to Articulate a Plan

Neither officer said that they articulated any plan on how to respond to the bank robbery call. In fact, the partner officer told Internal Affairs investigators that they had an "unspoken plan"[10] for most arrests and robberies. An "unspoken plan" is not the type of coordination that the Bureau trains and encourages and is significantly less preferable to an overtly communicated decision that ensures officers are working toward a common goal. Rather, the Bureau repeatedly stresses the need for partner officers to formulate and communicate a plan whenever they are involved in an operation. Here, as the officers were searching for the subject, they could have used the brief time to talk about what they would

[10] During the interview of the partner officer, the investigator described "this kind of unspoken decision to parallel and look for someone walking away from the scene."

do if they came across him. Unfortunately, this gap in the officers' response was not addressed in the Training Division Review.

> RECOMMENDATION 5: The Bureau should ensure that Training Division Reviews consider whether officers articulated a plan, and whether any failure to do so was consistent with training under the circumstances.

Involved Officers' Assessment of Risk

The partner officer told Internal Affairs investigators that, in considering the level of danger posed by the subject, it made no difference to him that radio transmissions had indicated there was no evidence that he had used or displayed a weapon during either earlier encounter. In a follow up question, he did admit that he wasn't aware of any cases in which the suspect had not displayed a weapon but turned out to have been armed. Nonetheless, he indicated that he would handle a response to a "note job" robbery the same way as if the broadcast informed him that the suspect was carrying a weapon.

Similarly, Officer Reagan told Internal Affairs investigators that he would handle a suspect involved in a "note job" robbery the same way that he would handle a suspect where a weapon was used or displayed.

Officers are taught to respond to suspects based on the degree of risk that they present. Certainly an individual who has committed a felony and displayed or used a weapon presents one of the highest risks for officers attempting to effectuate an arrest, while someone who is neither a suspect nor considered armed is at the other end of the spectrum. In this case, the information about the suspect known to the officers presented a degree of risk between these two scenarios: serious suspected crimes but without evidence of weapon possession. Accordingly, it is problematic for Officer Reagan and his partner to maintain that they did not take these gradations into account – instead responding as if the individual were known to have a gun.

While officers should and do understand that there is always some risk presented during every encounter, it is important to calibrate the risk and appropriate response based on the factors presented. During the Bureau's review, that lesson was not considered, nor was any feedback provided to the officers on how risk is to be calculated.

RECOMMENDATION 6: In officer-involved shooting reviews, the Bureau should assess the risk calculation of involved officers, and when appropriate provide additional training on how best to assess that risk.

Post-Incident Deployment and Use of Patrol Car

After the shooting, officers used a ballistic shield to safely and quickly approach Mr. Peeples to provide medical aid. However, Officer Reagan told the grand jury that after Peeples went down, he used the patrol car as a shield for other officers as they approached him in order to bring him into custody. While the idea of using the car in that way makes sense, it is unclear why the responding supervisor decided to use Reagan's car in that way, since there were clearly other available units that could have been similarly used. It is also apparent that other officers – besides the two involved in the initial encounter – were on scene and available to engage in this maneuver.

Basic recovery tactics teach not to contaminate a crime scene and move critical evidence (such as the positioning of the shooting officer's vehicle) unless necessary. For other reasons, it is preferable to excuse involved and witness officers to a deadly force incident from arrest duties if possible. The deviations from these principles that occurred in this case were seemingly avoidable. While the officers' quick approach and timely provision of medical aid is commendable, the investigation and review by Training and the area commander did not consider these questionable post-incident decisions.

RECOMMENDATION 7: Whenever evidence is moved at a crime scene, the investigation and analysis should consider whether there were alternative methods to accomplish post-incident objectives.

RECOMMENDATION 8: Whenever involved officers are also assigned a post-incident tactical role, the investigation and analysis should consider whether it was necessary to assign them such a role.

Action/Reaction Revisited

After the Detectives' interview, the attorney representing the partner officer asked him about training on action/reaction and how important it was to act before the other individual did. The investigator followed up on that question, which prompted the partner officer to respond that his takeaway from the training was that you needed to shoot first before the individual did.

By the time the partner officer was interviewed by Internal Affairs investigators, he volunteered the action/reaction principle as the reason he would have shot. The partner officer said he needed to do so before the subject had time to pull the object from his pocket.

When Officer Reagan was interviewed by Internal Affairs investigators, he was asked to review his training records and mentioned "action/reaction" as a training that would apply to this incident. The Internal Affairs investigator focused Reagan on "action/reaction" and Reagan explained that he was trained that if a subject was to pull a gun first, an officer would be "behind the eight ball" in reaction time.

When Officer Reagan testified in the grand jury, he began explaining his conduct in the terms of action/reaction unprompted and almost immediately.

The Training Division Review speaks of the Action/Reaction principle in reviewing Officer Reagan's decision to use deadly force:

> *In a contest of time, the initiator has an advantage. When we react to a stimulus we must perceive it, process it mentally, formulate a response and then begin the response. This normal human performance limitation puts us at a comparative time disadvantage against the initiator. The police must account for this in their tactics by employing other advantages to reduce the potential impact of the action-reaction delay. We may also use action-reaction to our advantage as a tactical edge in encounters.*

Then without further discussion, the Training analysis concludes that Officer Reagan's actions demonstrated sound and effective tactics.

In our Sixth Report (January 2019), we spoke of the Action/Reaction training that the Bureau presents to officers and our concerns that these principles, unless appropriately limited or carefully explained, can become a blanket explanation/justification for any use of deadly force. This case presents another illustration of how Action/Reaction (much like the "furtive movement" explanations of the past) is relevant but not inherently conclusive, and should always be accompanied by a broader factual analysis of threat factors. We recognize that this incident was analyzed prior to that Report's publication, but believe that this issue is sufficiently important to revisit here.

In this case, instead of a reference to the principle and a summary conclusion that Officer Reagan tactics were "sound and effective", the Training Division Review could have and should have weighed the following:

- While the subject had allegedly robbed a bank, there was no indication that he displayed a firearm or indication that he was armed during that encounter;
- The subject was slowly walking down the street and did not attempt to flee when encountered by police;
- The officers were twenty yards away from the subject when they addressed him and had the advantage of distance, providing them additional time to react to any perceived threat;
- The officers had taken positions of concealment and partial cover behind the patrol car doors, heightening their protection from any firearm assault;[11]
- The subject did not obey commands to show his hands; and
- The subject pointed a black object at the officers in a shooting stance position.

Given the last two factors in particular, the Bureau may have well decided that it was consistent with its expectations that Officer Reagan used deadly force under the risk factors presented to him. However, the other factors arguably militated in

[11] Some but not all of the Bureau's patrol cars have been equipped with ballistically rated door panels which offer significantly greater protection from firearm assaults than the ordinary patrol car door. It was unclear whether the patrol car driven by the involved officers in this case had ballistic door panels but being behind *any* door is tactically preferable to finding oneself without any cover or concealment. We were advised that it is not inherently obvious which Bureau cars have ballistic protection. The Bureau may wish to consider ways to better identify those vehicles as it would be helpful for officers to know as they start each shift whether the car they are driving is equipped with ballistic doors.

favor of another instant or two of assessment by the officer before firing at what turned out to be an unarmed individual. To be clear, our point is not to expect perfection from officers in these dynamic situations. Instead, we would have the Bureau "show its work" regarding a more full-fledged analysis. That analysis could certainly have reached the same conclusion – without treating Action/Reaction as both the beginning and end of any conversation to which it applies.

The Bureau's analysis also should have considered whether other options were available short of deadly force. The partner, in fact, had retreated and moved to reposition himself rather than immediately using deadly force when he could not acquire a sight picture.

In addition, the view articulated by the partner officer that he would have used deadly force when he observed the subject begin to withdraw his hand from his pocket also should have been analyzed. To allow that opinion to go unchallenged essentially endorsed the calculus of the partner officer that deadly force was appropriate, even before the subject produced his wallet from his pocket and pointed it at the officers and when, by the officer's own admission and actions, other options were available.[12]

Accordingly, and for purposes of emphasis, we reiterate our recommendation from our Sixth Report here:

> RECOMMENDATION 9: The Bureau and Police Review Board should ensure that officer-involved shooting reviews do not begin and end with a citation to the action-reaction principle but must critically assess other tactical options that might have driven a different result.

Decision Not to Wait for Additional Officers to Respond

Officer Reagan said that when they saw a man matching the description of the bank robbery suspect, they broadcast that they were with him. While the two on-scene officers were aware that there were numerous other Bureau units

[12] The partner officer told investigators that there was "no doubt" in his mind that the subject was armed with a firearm. Investigators did not follow up on this question, despite the fact that Mr. Peeples was, in fact, not armed.

responding to the bank robberies, were likely in the immediate area, and would be responding to their broadcast, they chose to engage Mr. Peeples immediately rather than wait for additional units to arrive. Reagan said he hoped to "low key" the encounter to gain compliance from the subject.[13] While his explanation has some appeal, the Bureau did not consider whether it would have been preferable for the officers to wait for additional officers. Having additional officers on-scene obviously provides a greater range of tactical options. While the Bureau may have concluded that the officers' choice not to wait for additional resources was the most sensible under the circumstances, it would have been important for the training experts and other reviewers to consider this tactical option in reviewing the incident.

> RECOMMENDATION 10: Bureau officer-involved shooting protocols should be modified to require routine discussion and analysis regarding any decision by officers not to call or wait for additional officers to arrive before tactically engaging a subject.

Investigation and Review

Questionable Use of the Behavioral Health Unit

Within the Bureau is the specialized Behavioral Health Unit (BHU), which is tasked with coordinating the police response to individuals with mental illness or in behavioral crisis. As indicated on the Bureau's website:

> *The mission of the Behavioral Health Unit is to coordinate the response of Law Enforcement and the Behavioral Health System to aid people in behavioral crisis resulting from known or suspected mental illness and or drug and alcohol addiction.*

In this case, the day after the incident, detectives who were investigating the officer-involved shooting visited with Mr. Peeples at the hospital where he was

[13] Officer Reagan also suggested that they needed to take action because Mr. Peeples was heading toward a busy street where others might be endangered by him. In addition to the speculative nature of this concern, Officer Reagan was not asked why he did not position his patrol car between Peeples and the busy street.

receiving care. They asked him if he was willing to talk to them but he invoked his Constitutional right to remain silent.

Two days later, detectives asked the BHU to respond to the hospital to talk to Mr. Peeples. According to the report later prepared by the BHU officers, they were tasked by detectives with asking Peeples about his mental health history. While the notes of that subsequent interview indicated a wide-ranging inquiry into that subject, a significant part of the interview focused on Peeples' actions relating to the shooting. This information was later used by the Commander in recommending that Officer Reagan's use of force be found in policy.

The visit by the BHU is concerning for a few reasons. First, two days earlier Mr. Peeples had invoked his Constitutional right against self-incrimination. Before further interrogation can occur, police must ask an individual whether he wishes to withdraw such an invocation, and there is no evidence that such an interplay occurred.[14] Moreover, the officers clearly went beyond their mission of the mental health inquiry and delved heavily into the actions Peeples took immediately prior to the use of deadly force.

An additional problem with the BHU interview with Mr. Peeples is that it was not recorded. As a result, there is no verbatim account of what transpired. Bureau investigative protocols dictate that interviews are to be recorded and then transcribed. The lack of a recording compounds the issues surrounding the hospital visit by BHU.

More programmatically, using BHU as an investigative arm is in conflict with the unit's mission to coordinate a law enforcement response with available assistance from Portland's behavioral health system. Using information obtained from the person shot by BHU to "clear" an officer in a use of force incident has the potential to undermine the necessary trust relationships that BHU must maintain among the mental health community. While a contact with BHU may have been helpful for purposes of identifying whether Mr. Peeples had a history of mental illness, personnel crossed a line when the inquiry focused on Peeples' actions during the event itself.

[14] We have no reason to believe that the information obtained by BHU was used in the criminal case against Mr. Peeples, but our other concerns about the deployment of BHU in this fashion remain.

RECOMMENDATION 11: The Bureau should develop protocols to ensure that the Bureau's Behavioral Health Unit's resources are not used for a purpose inconsistent with its mission.

Development of Expertise in Collecting Video Evidence

In this case, the Bureau documented in detail its efforts to obtain surveillance video of the events proceeding the use of deadly force and unsuccessful attempts to obtain any video of the deadly force incident itself. We note in particular that the Bureau relied on an officer who has developed expertise in video to assist with the collection of the various video security systems that neighboring businesses used. Considering the increased complexity and variability that exists, the Bureau is encouraged to continue to use any special expertise of its personnel in retrieving and reviewing video evidence of critical incidents.

Subjects' Medical Records & Toxicological Reports

The investigative materials do not include Mr. Peeples' medical records. Moreover, there was no apparent effort to obtain or analyze any toxicological evidence. The medical evidence documenting Peeples' injuries, including bullet wound entrances/exits and an analysis of the blood work already being collected by medical staff would have provided relevant information for review. While medical privacy interests and laws provide some challenges to investigators, they can be overcome by requesting a waiver from the patient or through a search warrant application. That neither was done resulted in relevant information not being captured during the criminal investigation.[15]

[15] The Bureau advised that detectives did not seek to obtain medical or toxicological records in this case because the District Attorney had advised them that they were not needed. While the District Attorney can request additional information needed to complete a criminal investigation, the Bureau should be primary on providing systemic guidance to its investigators on what minimally is required for an initial officer-involved shooting investigation. Progressive officer-involved shooting investigation protocols require investigators to obtain medical and toxicological records. The Bureau's protocols should likewise so require.

RECOMMENDATION 12: The Bureau should modify its protocols so that investigators are tasked with either collecting medical and toxicological evidence in cases where individuals are injured but not killed in police shooting or documenting their inability to do so.

The Non-Existence of a "Perfect" Shooting

When Portland's review process identifies issues involving officer decision-making, it is evidence that the exacting review demanded of these critical incidents is in place. In this case, however, neither the Training Division Review, the Commander's Review, nor the Police Review Board identified one issue or advanced one question about the decision making of the involved officers. As noted above, there were several decisions that could have been considered and addressed during the review of this incident. Short of finding the shooting "out of policy," there were a number of potential remedial measures that could have been advanced to better prepare the involved officers and the Bureau as a whole for future similar encounters. That the Bureau's review mechanisms failed to identify any of these issues calls into question the exactitude with which these serious incidents are being considered. In our review of hundreds of shootings, we have yet to find one where the response and decision-making were not worthy of such analysis. Even if the eventual analysis finds nothing that the involved officers could have done better, going through the analysis in writing is a worthy endeavor.

In this case, a man was shot by officers when he pulled out a wallet and pointed it at them. A decision point analysis that factually addressed, identified, and evaluated the officers' decisions was warranted. It was also worthy of a greater effort to endeavor to identify alternative strategies that might prevent future uses of deadly force, particularly against unarmed subjects.

Training Staff Testimony to Grand Jury

During the grand jury presentation of this matter, a Bureau officer assigned to the Training Division was asked by the prosecutor whether the use of deadly force by

Officer Reagan was consistent with the Bureau's deadly force policy. She replied that it was consistent with policy.[16]

While the policies of the Bureau on deadly force are relevant to an officer's state of mind in a criminal context, the testimony of the Bureau officer in the grand jury was premature and her opinion was based on an incomplete record. In this instance, there is no evidence that the training officer based her opinion on anything other than a characterization of Reagan's testimony provided to her while on the stand. The presentation of this testimony was problematic for a number of reasons we discuss more fully below.

Timeliness of Involved Officer Interview

Officer Reagan was interviewed two days after the shooting. As we discuss more fully below, this is too long to wait to obtain an account from the individual most knowledgeable about why he used deadly force, the shooting officer himself. The delay in this case had potentially significant consequences. Prior to Officer Reagan being interviewed, the Bureau released the following information about the incident:

> *The officers were approximately 50 to 60 feet from him as they gave the suspect commands to put his hands in the air. The suspect did not follow the officers' commands, turned towards the officers and advanced towards them as he reached into his pocket. Officer Reagan fired multiple shots from his handgun, striking the suspect.*

Media outlets reported this information, presumably derived from the interview of Officer Reagan's partner, before Reagan was required to provide an account of his actions. It is unclear to what extent Reagan was exposed to this information, but best investigative practices demand that witnesses be interviewed prior to any possibility of contamination from other sources. The 48-hour rule still allows for the possibility of that contamination.

[16] Even though not at issue in this case, the Training Bureau officer was also asked if the partner officer had used deadly force, whether it would have been in policy and she also responded affirmatively to this hypothetical question.

Timeliness of Investigation

This case was completed in 219 days, 39 days past the 180-day deadline. In prior reports, we have seen extensive analysis of why a case was late and what entity was responsible for going past internal deadlines. We did not see such an analysis in the investigative materials, but the source of the delay here appears to be the three and a half months it took for the Training Division Review to be completed after the Internal Affairs investigation was submitted.

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March 8, 2018 Sarah Brown

PPB officers responded to two burglary calls on the evening of March 7, 2018 within a block of each other: one at a house, the other at a hotel. They searched and took statements from the witnesses. Very early the next morning, during the hours of darkness, they received another call about a prowler at the residence that was the location of the first burglary call. At the March 8 early morning call, several officers, two supervisors and a K-9 again searched the house.

When the K-9 handling officer descended the exterior stairway to the backyard to put the K-9 in his patrol car, the dog alerted to a small storage area under the stairway with a closed metal door. Officers called to whomever might be inside the storage area and got verbal but unintelligible responses from behind the metal door that sounded like a "muffled female's voice." Sergeant Grant Smith and acting Sergeant Benson Weinberger formed a plan with Officers Darrell Shaw and the K-9 handler to contact the subject in the storage area. Weinberger was to use his Taser as a less lethal option if necessary, while Shaw would provide lethal backup to the Taser. Smith would take hold of the subject if she did not respond to verbal commands. The K-9 handler was present, controlling his dog.

Sergeant Smith and Officer Shaw pried the door open and saw a woman with a handgun pointed at them about two feet away. Shaw and Smith yelled "gun" and jumped back. Shaw drew his gun and he and Smith, Weinberger, and the K-9 officer, backed away quickly and sought cover. Officer Shaw yelled commands to drop the gun as he retreated. The subject, later identified as Sarah Michelle Brown, pulled back into the storage space but, after a short while, stuck a hand out with the gun in it. Shaw saw the gun point at him and fired two or three rounds from his pistol at the hand and gun. The hand with the gun became visible extending from the storage area, then retreated, then repeated this pattern over a period of about twenty minutes. Witness officers observed that sometimes the gun appeared to wave aimlessly and other times it seemed to be aimed by Ms. Brown at officers. Shaw fired two or three more shots when he saw the gun point at him a second time.

Supervisors, an officer with Enhanced Crisis Intervention Team, and a female officer posing as a dispatcher tried to negotiate with Ms. Brown but she refused to surrender, threatened to shoot them and continued to wave the gun around,

sometimes pointing it with apparent intention. Officer Joseph Webber arrived with an AR-15 rifle and took a position near the northeast corner of the house, where Officer Shaw was. After observing Brown extend her arm from the storage area, wave the gun around then point it directly at him and other officers and say, "I'm going to shoot you," he fired at the hand and gun, the only portion of Brown he could see. He did so the next two times Brown appeared to aim at one or more officers.

Acting Sergeant Weinberger and other officers yelled for her to drop the gun, but she kept yelling and did not respond to these orders. After firing a second volley from his rifle, Officer Webber and the Enhanced Crisis Intervention Team officer trying to negotiate with Brown observed her fire her gun. Webber returned fire and one of his rounds hit her hand. She dropped the gun and, when next observed, her hand was bloody. Officers continued trying to negotiate with Brown, but she would not come out of the storage area, saying she did not believe they were police and that she wanted to talk to a dispatcher and would shoot anyone who tried to approach her.

SERT officers arrived and deployed a robot which conveyed a telephone and then water to Ms. Brown. SERT eventually took Brown into custody without further use of force. She received medical care for wounds to her hand and leg from which she recovered.

During the incident, Officer Shaw fired a total of four rounds from his pistol and Officer Webber fired twenty-two rounds from his AR-15 rifle. The evidence at the scene indicated that Ms. Brown fired four rounds from her pistol.

Two weeks after the incident, a grand jury indicted Ms. Brown on charges that included attempted murder, reckless endangerment of another, burglary and theft. The grand jury also found that Officers Shaw and Webber had been legally justified in using deadly force. The Unit Commander and the Police Review Board found that the actions of the officers and supervisors were within policy. A minority of members of the Police Review Board agreed with observations in the Training analysis suggesting that supervisors should have assigned more personnel before engaging the suspect. The Chief found the actions of the supervisors in policy but recognized that the on-scene sergeants had taken an active, hands on role in the attempted apprehension of Brown when it was not absolutely necessary. They were referred for a debriefing on how such decisions in the field can compromise effective supervision.

Timeline of Investigation and Review

3/8/2018	Date of Incident
3/22/2018	Grand Jury Proceedings
5/10/2018	Internal Affairs Investigation completed
7/2/2018	Training Division Review completed
9/4/2018	Commander's Findings completed
11/1/2018	Police Review Board
11/15/2018	Case Closed

OIR Group Analysis

Tactical Decision-Making

A steel door to a small storage area is pried open to reveal a woman pointing a handgun at the heads of the police officers standing before her. The officers move away from this deadly threat, beating an understandably hasty and disorganized retreat. These dangerous circumstances are at the heart of the tactics in an incident that ultimately resulted in the use of deadly force.

Police trainers invariably emphasize three keys to officer safety whenever they consider operational decision-making: time, distance and cover. One or all of these can increase protection and give officers in the field the space they need to assess their options and make the best decisions under the circumstances. Officers should actively seek to maximize these factors whenever high risk or potential surprise present themselves. A closed, opaque container with a subject in it, such as a closet, a storage shed or, in this case a storage space under an exterior stairway with a steel door, is a foreseeable combination of potential surprise and high risk. In this case the subject was also perceptibly angry and possibly irrational based on her unintelligible yelling from behind the door and her apparent attempt to keep the door from being opened by pulling from the inside. These circumstances presented a clear opportunity – or arguably even a

necessity – to step back, consider the risk factors and explore potential safer alternatives to yanking the door open. The Training Division, in their analysis of the incident, found the officers and supervisors reaction to the sight of the subject's gun reasonable, but never addressed the supervisors' initial decision to pry open the door with incomplete knowledge of the threat that awaited them.

The subject had shut herself in with no alternative exit, and the officers had no element of surprise to preserve. Therefore, there was little urgency to confront her face-to-face. When Ms. Brown did not respond to police orders to put down her weapon and come out, she became a barricaded subject, a circumstance justifying at least a supervisor call to confer with the Bureau's Special Emergency Reaction Team (SERT) and the Crisis Negotiation Team. SERT was called by a supervisor at the scene about five minutes after the first shots were fired. SERT arrived about half an hour later and were able to arrest Brown, but not before two patrol officers – Officer Shaw and Officer Webber fired their guns and Brown fired her weapon.

> RECOMMENDATION 13: When Bureau officers attempt to breach the entrance to an opaque closed structure with subjects inside, this is a high risk encounter and investigators and reviewers – including Internal Affairs, Training, and the Commander – should explore and consider whether safer tactical alternatives existed to forcing the entrance open. This would include considerations of (1) whether the arrest team could take safer positions or employ mobile cover such as ballistic shields before opening the entrance; and (2) whether it would be practical and prudent to delay forcing the entrance until the arrival of SERT and crisis negotiators.

Consideration of this chain of events also leads directly to the question of cover. Did the officers find adequate cover when they first retreated from the open storage door and, if not, could they have found better cover without endangering themselves? Officer Shaw retreated toward the northeast corner of the house, still in line of sight to the open door of the storage space when he fired a second volley of rounds because he still had no cover and saw Brown's gun point at him again. He did not fire again after reaching the cover of the corner of the house but stated that was only because Brown did not point the gun in his direction again. The sergeant, acting sergeant and K-9 handler had headed in another direction where they were not looking straight into the open storage door. Sergeant Smith and Acting Sergeant Weinberger then repositioned and risked crossing into the field

of fire to join Officer Shaw at the northeast corner of the house, because, as Weinberger put it they knew they were in a "bad spot," out on the back lawn with no cover or concealment. When they reached the corner of the house, Sergeant Smith ordered a ballistic shield be brought to their location to improve the cover – a constructive move but not a complete solution. In fact, Officer Webber took the same problematic position of cover near Officer Shaw when he arrived and felt similarly vulnerable, because, he stated, despite having a ballistic shield, he had to step partially out of cover to look down the sites of his rifle. Thus, when he saw the hand and the gun point directly at him, he feared for his life and fired his rifle. This happened three different times.

The supervisors, once they were away from the open steel door, had the apparent time and opportunity to survey their situation, improve their cover and coordinate a response with the other members of the team. They did use this time to try to de-escalate the situation, engaging the subject in dialogue, employing a ruse to satisfy her demand to talk to a dispatcher, and promising immediate medical attention for her wounds. These were all positive steps. Yet there was no apparent reconsideration of moving officers to safer positions and holding the scene prior to SERT's arrival.

In this case, the Bureau personnel had time – both before the door was pried open and after the first shots were fired – to consider their options. The setting itself (a three-story house with landings, porches, balconies, opaque hedges and retaining walls all around the opening to the storage space where the subject remained) presented a wide array of potential hard cover options. Even the officers who were at the vulnerable northeast corner of the house had access to the other parts of the house and grounds. The officers would have been familiar with the basic layout after their initial search. Some of these options would also have provided an opportunity to maintain observation of Brown from a safer distance or from an angle of which she might not yet have been aware.[17]

While the Training Division suggested that the field supervisors could have used more of the available officers to assist before opening the storage area door, neither the Training Division Review, the Commander's Memorandum, nor the Review Board considered whether Bureau personnel might have responded differently after they encountered Ms. Brown and realized that she had a firearm. Because it was very dark in the back yard and the officers and supervisors had to

[17] SERT, in fact, utilized some of these other vantage points for purposes of observation and potential use of lethal force when they arrived.

make quick decisions under stress, the reviewers may have been reluctant to second guess the decisions of those being threatened by Ms. Brown's gun. Nevertheless, because the Bureau's reviewers declined to consider alternative tactics, a potential learning opportunity for addressing future similar challenges was forfeited.

> RECOMMENDATION 14: The Bureau should emphasize alternative ways to approach an armed or possibly armed subject, as well as options for improving cover and explore these issues as a component of the analyses performed by its subject expert internal reviewers, specifically the Commander's Review and the Training Division Review. This component would be most effective if stated separately from the policy determination.

Tactical Engagement by Sergeants

As the incident unfolded, Sergeant Smith was the first to grab hold of the door handle, brace his foot on the door frame and pull. It is not optimal for supervisors in the field to place themselves in a position where they can no longer supervise because they have engaged tactically. In some circumstances, supervisors cannot predict where the focus of action will be, but this was not the case here. In other circumstances an emergency can arise that requires all hands to engage, but this also was not the case here. The officers and the two sergeants conferred beforehand. The sergeant and the acting sergeant essentially assigned themselves to "go hands on," and to prepare to use a less lethal weapon, respectively, with Officer Shaw preparing to use a lethal weapon – his pistol – as a backup if necessary. The K-9 officer was simply to hold onto his dog. This arrangement consciously placed the two sergeants as number one and two into the breach; the most likely to encounter the subject physically and the two most likely to be at immediate risk. In fact, Ms. Brown was pointing the gun in Smith's face when the door opened.

While Officer Shaw was the designated "lethal back up," he instead holstered his gun in order to help pull the door to the storage area open. This was at the moment just before PPB personnel expected to see the subject. It was foreseeable that when they did, she would be very close because of the small size of the storage area. That the supervisors designated a lethal backup shows that they considered the possibility that the burglary subject might be armed. Conversely, the fact that they allowed the officer to put his gun aside in order to force the door

and that they were surprised to see a gun in the hand of the subject may show that the supervisors did not take the potential threat very seriously.

We have written repeatedly about the importance of on-scene sergeants maintaining a supervisory perspective, avoiding tactical involvement, and delegating these roles to officers in their command. To the extent that clear assessment and decision-making did not appear to be occurring, the moment before the shed door was forced open in this case exemplifies how direct engagement can be distracting for a field supervisor.

The Bureau has responded to our frequent recommendations in this area with agreement and the assurance that current practice and training emphasizes this supervisory role for sergeants. The Chief's decision to order a debriefing for the involved sergeants here is evidence of the Bureau's recognition of the importance of this issue and signals progress toward full implementation of our prior recommendations.

Preservation of Evidence

It has become routine for supervisors at the scene of an officer-involved shooting or other critical incident to separate the involved officers once the incident is over and to arrange for an uninvolved officer to wait with each. Bureau policy also requires involved officers be instructed not to change their clothes and keep their weapons secured until detectives examine and photograph them. This is in accord with best police practices following an incident of this nature.

In this case, however, the reviewing Commander pointed out that the documentation indicating that these procedures took place was not complete. Some of these important procedures to preserve the integrity of the evidence, or even potentially plausible reasons why unique circumstances prevented some of those procedures, were not discussed in the interviews of the involved officers or supervisors either. This information could perhaps be more reliably preserved by providing formatting in a modified report template for field supervisors that requires an entry covering separation, admonition and chaperoning of involved officers. Alternatively, Internal Affairs investigators could explore ways to make certain to address this information in their post incident interviews.

Timeliness of Interviews and Review Process

The involved personnel who fired weapons in this incident were interviewed two days after the incident. While this is an improvement over the weeks (and sometimes longer) it has taken in the past to obtain statements from involved officers, it is still not ideal, for reasons we discuss more fully below.

This case was not closed until nine weeks after the 180-day deadline imposed in the settlement agreement with the Department of Justice. The excess time appears attributable mainly to delays before completion of the Commander's review and setting a date for the Police Review Board to convene.

April 7, 2018 ◦ John Elifritz

Officers interacted with John Elifritz a number of times on April 7, 2018, ending with a confrontation inside a meeting room at CityTeam Ministries in the central eastside of Portland just before 8:00 p.m. Mr. Elifritz had first come to the attention of officers earlier in the day, at around 2:25 p.m., when he called 911 to report that his wife and daughter had been killed. Officers responded and found his family unharmed, while other officers and a sergeant located Mr. Elifritz. He pulled a knife from his pocket and held it to his own throat. Officers attempted to talk to him, but he said he wanted to be left alone. He lowered the knife from his neck, and denied any desire to hurt himself or anyone else. At some point, officers decided to disengage and refer the matter to the Bureau's Behavioral Health Unit for later follow up.

While those officers were still in the area, debriefing the encounter, someone drove up to them to report that a man with a description matching Mr. Elifritz had just walked up to his car waving a knife and attempted to open the car door. That individual did not want to pursue criminal charges and left. The sergeant and officers again decided that continued disengagement was the best course of action.

About two hours later, a man called 911 to report that his daughter's vehicle had been stolen by force by a man who matched Mr. Elifritz's description. Around three hours after that, dispatch received another 911 call about a road rage or menacing incident. A man in a vehicle that appeared to be the one stolen in the earlier carjacking was reported to be driving erratically, pulling up next to the caller's vehicle while driving through the bike lane. While initial reports said the driver may have pointed a gun, the officer who responded to this call determined, after talking to the caller and watching a video one of his passengers had recorded, that there was no gun involved.

Several minutes after the menacing call, dispatch received multiple 911 calls about a man who had jumped out of a moving vehicle at a busy intersection and who appeared to be drunk or high. That vehicle crashed, and officers determined that it was the same one that had been stolen around three hours earlier. As all these calls were being put together to point to the same subject, officers began converging on the area, looking for Mr. Elifritz.

About 15 minutes later, at around 7:45, there was another 911 call about a man matching the description of Mr. Elifritz, from a convenience store employee. The man had pulled out a knife and spoken with the employee prior to leaving the store. The next call came about 10 minutes later, regarding a report that a subject was outside a shelter holding a knife to his neck. Officers learned later that at around that same time, the subject (later identified as Elifritz) had held a knife to the neck of a man outside that shelter. The subject left that man uninjured and went across the street into CityTeam Ministries (a shelter and service center serving those experiencing poverty, homelessness, hunger, or addiction), where officers located him several minutes later, just before 8:00 p.m.

This series of events had been broadcast via radio (with less detail and specificity than recounted above) and the responding officers expressed a general awareness that the subject inside CityTeam had been connected to these earlier events.

The first officers to arrive gathered just outside the building in a double doorway that looked into a large meeting room, where somewhere between 20 and 40 people were gathered. Most were sitting in chairs, and others were laying on the floor or walking about the room. Mr. Elifritz was on one side of the room, near the door.

Security videos from the incident show Mr. Elifritz wielding a knife and stabbing or cutting himself in the neck as he moves toward the center of the room. Other individuals are clearly reacting to the presence of the knife, getting up from their chairs and moving away from Elifritz. Some exited to other parts of the building through interior doors. A couple of people seem to be addressing the subject, and moving chairs around in an effort to create barriers between themselves and Elifritz. Others seem either to not notice or to be willfully ignoring Elifritz's movements. In the center of the room there is a half wall surrounding a staircase down to a lower level.

The first group of officers at the building were quickly joined by a number of others as they responded to the ongoing calls. The officers gathered very briefly in the doorway. Two officers at the front of the group – Richard Bailey and Justin Damerville – were armed with less-lethal 40 mm rifles. They observed Elifritz both holding the knife to his own neck and waving it around, moving among the people in the room. They saw blood coming from his neck, and saw that others in the room appeared to be scared and unsure about where to go. From the threshold, both Officers Bailey and Damerville warned they were going to fire,

and then fired less lethal rounds.[18] The projectiles hit Elifritz in the thighs, but did not cause more than a flinch in pain. He did not comply with officers' commands to drop the knife.

The officers did not discuss a plan for addressing the subject, but all articulated the motivation to move quickly into the room to separate the subject from the 15-20 uninvolved civilians who were still milling about. Most of the officers stated they advanced into the room together without expressly communicating, but in a manner that made them feel like everyone was on the same page. Sergeant Roger Axthelm was present in the doorway and recalled that he instructed officers to move into the room.

In addition to the less-lethal operators, three officers – Kameron Fender, Bradley Nutting, and Chad Phifer – carried AR-15 rifles; and one – Alexandru Martinuic – carried a shotgun. One K-9 officer entered the building with his dog. Twelve others, including the sergeant and Officer Andrew Polas and Multnomah County Sheriff's Office Deputy[19] Aaron Sieczkowski, entered the building with all of their standard equipment and tools (including handguns and Tasers[20]).

Officers moved into the room and formed an "L" along two walls of the room. Some officers maintained a focus on the subject, and continued giving commands to drop the knife. Others focused their attention on the civilians toward the back of the room, many of whom seemed to be nearly frozen with apparent uncertainty about where to go. Officers began giving them orders to move out and tried to use their presence to create a pathway where they could safely exit the room. In addition to getting these individuals away from the danger presented by the subject, officers later articulated their concerns that they needed to get everyone out from behind the subject, because their presence limited officers' ability to use deadly force if the subject attacked any civilians or aggressed toward the officers.

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[18] The Bureau had transitioned from beanbag shotguns to 40-mm rifles firing compact foam projectiles shortly before this incident. In their warnings to the subject, the officers referred to their less-lethal rounds as "beanbags" because they had not developed convenient terminology for the new system.

[19] This deputy was partnered with a Clackamas County Deputy and assigned to Transit Division. They happened to be taking a lunch break in the area and had responded to the initial carjacking call to help with the area search for the subject.

[20] When asked, each of the involved officers stated they did not believe the Taser was an appropriate force option for this scenario because it would have required them to get much closer to the subject, increasing the risk presented by the subject's knife.

The atmosphere inside the room was universally described as loud and chaotic. As officers continued to address Mr. Elifritz, Officers Bailey and Damerville fired additional less-lethal projectiles, still to no great effect. Elifritz was toward the back of the room approximately 20-30 feet from the group of officers. Officers had been in the room for less than a minute when Elifritz took several steps toward them, and six officers nearly simultaneously fired their weapons.

Deputy Sieczkowski fired his handgun once. Officer Polas fired his handgun six times. Officer Fender fired his rifle four times. Officer Phifer fired his rifle twice. Officer Nutting fired his once. Officer Martinuic fired his shotgun three times. Elifritz was struck nine times and immediately fell to the floor.[21]

Officers briefly held their positions while continuing efforts to clear the remaining civilians from the room. Though Mr. Elifritz was not moving and the large amount of blood on scene suggested he was deceased, Sergeant Axthelm directed Officers Bailey and Damerville to fire two additional less lethal rounds.[22] Elifritz did not respond to these, and Axthelm approached and briefly rolled Elifritz to his side to kick the knife[23] out from under him. He showed no signs of life, so the sergeant called for paramedics to approach. They pronounced Mr. Elifritz deceased.

The availability of surveillance camera video of this incident eliminates the need to estimate the timing of events. The first officers arrived at the doorway to CityTeam two minutes and seven seconds after Elifritz entered. Officers entered the building one minute and 31 seconds after the first officers arrived. The shooting occurred 35 seconds after their entry. Sergeant Axthelm[24] approached Elifritz one minute and 55 seconds later. Just under a minute after that, paramedics were on scene tending to Elifritz.

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[21] There were at least 20 identified strikes from bullets or shotgun pellets to the walls, pillars, and furniture behind and around Mr. Elifritz's location.

[22] Through the entire incident, Officer Bailey fired his less-lethal rifle a total of four times. And Officer Damerville fired his five times.

[23] The knife was a folding knife with a two-and-a-half-inch blade.

[24] We have in the past questioned sergeants' decisions to insert themselves into tactical roles. Here, Sergeant Axthelm's decision to approach Mr. Elifritz made sense because it seemed clear the subject no longer presented a threat, the sergeant is a trained EMT who was best positioned to render any necessary aid, and there were other sergeants on scene who stepped into supervisory roles.

The autopsy revealed evidence of six less-lethal strikes – all on the thighs – six gunshot wounds, and three shotgun wounds. Of these, four were wounds to the upper abdomen, chest, and shoulder that were likely fatal. Two others struck Elifritz's in the hands, one in the leg, and two more passed through tissue or lodged in muscle in a way that would have been readily treatable. The Medical Examiner also described a number of cutting wounds to Elifritz's neck, none of which did any major damage that would have led to his death. The toxicology screen revealed a level of methamphetamine in his system that, coupled with his behavior, indicated likely intoxication.

The District Attorney presented this case to the grand jury, which concluded no criminal charges should be filed against the involved officers. The Police Review Board recommended that the shooting be found in policy, but some members of the Board also recommended a debriefing for the involved sergeants regarding the need to take a more assertive role and assign tasks to officers as well as ensure that individuals are appropriately assigned to make required notifications. The Chief concurred.

The Responsibility Unit Commander and Training made additional recommendations about using the incident to explore ways to update the Bureau's active shooter training to include responding to threats posed by people with weapons other than firearms. While those were not formally adopted by the Board or Chief, Training has revisited its active shooter training to address concerns about different types of threats.

Timeline of Investigation and Review

4/7/2018	Date of Incident
5/9/2018	Grand Jury concluded
5/16/2018	Internal Affairs Investigation completed
7/26/2018	Training Division Review completed
8/21/2018	Commander's Findings completed
11/28/2018	Police Review Board
12/13/2018	Case Closed

OIR Group Analysis

Tactics and Communication

Before entering a building to address an armed subject, in a scenario that does not involve unengaged community members, officers ideally would gather outside the building and develop a coordinated plan for addressing the subject. They would designate certain members to take on different tasks and to use various tools. They would bring their on-scene Enhanced Crisis Intervention Team members to the forefront to try to establish some rapport with the subject, to calmly communicate with him and convince him to surrender any weapons. If Mr. Elifritz had been alone inside the CityTeam building, this would have been the approach most consistent with how the Bureau trains its officers. But in this scenario, there were numerous other people in the room, and all of the officers present were focused on the threat that Mr. Elifritz presented to these individuals, expressing their obligation to intervene quickly to protect them.

Despite the absence of one person taking charge and designating roles, officers rather organically moved into various positions, in accordance with their experience and training. For example, when Officer Bailey arrived on scene, he recognized that Officer Damerville was already there with his less-lethal rifle but knew it is best to deploy two less-lethal weapons because of the time it takes to reload. Because he is certified with the less-lethal rifle, he deployed it and took a position next to Officer Damerville.

Some officers who arrived after the initial officers said they assumed someone had been taking charge and coordinating, because when they arrived, there were people deploying different weapon systems, and others who seemed to be keeping their hands free to address other concerns. One officer returned to her car to retrieve a trauma/first aid kit. This level of coordination in the absence of clear supervisory direction speaks to the tactical acumen of these involved officers.

As officers assembled at the threshold, Mr. Elifritz grabbed one of the civilians in the room, who was able to pull away and shake him off. Some witnesses interpreted his actions to mean that he intended to wrap someone up and hold him as a hostage or shield. Ultimately, none of the community members in the room was stabbed or otherwise injured, but they later described themselves as being afraid, or in shock or confused. Some tried to talk to Elifritz, but all consistently said he was acting irrationally and seemed high on something.

There was no express communication about how and when to advance into the building, but all the officers generally described the same concerns and thought processes. As Mr. Elifritz ignored commands and seemed unbothered by the multiple less-lethal projectiles while continuing to move around the people still in the room, they described an urgency to intercede.

While not all officers reported hearing Sergeant Axthelm's instruction to move in, they entered as a group, moving into an "L" formation along two walls of the room. Ideally, the sergeant could have taken charge more assertively, making assignments and more clearly directing officers' movements. Three of the seven voting members on the Police Review Board acknowledged as much when they recommended an "in policy" finding, but with a debriefing for the involved sergeant. Three other Board members did not agree with the recommendation for a debriefing, noting that the sergeant was aware and keeping track of the different resources and tools deployed, and was appropriately focused on protecting the community members inside the room.

The Training Division Review discussed the officers' movement into the room favorably, while acknowledging that it is not something that has been formally trained. The analysis commented that the formation was similar to training for active shooter scenarios, providing officers multiple angles from which to address the subject while at the same time establishing a barrier or pathway for individuals to get out of the room. Training concluded that this formation made the most sense for this situation, as evidenced by the fact that officers moved into position without any discussion or planning, and each described the intended objective in similar ways during subsequent interviews.

The Commander's memorandum recommended that the shooting and tactics surrounding it be found in policy, but also recommended a tactical debriefing with each of the involved members with the goal of developing additional training for future similar scenarios. Specifically, the Commander recommended that the Training Division consider revising its training for active shooters to more broadly encompass threats such as the one posed by the knife in this case. The Police Review Board and Chief did not formally accept this recommendation, but the current in-service training required of all PPB officers includes a one-day class on critical incident response, the curriculum for which was informed, in part, by the circumstances of this officer-involved shooting.

AR-15 Rifle Deployment

The three officers who carried AR-15 rifles ended up firing at Mr. Elifritz. While in less dynamic scenarios, there may be one or two designated rifle operators, here officers each made independent judgments about which weapons to deploy when they arrived at the scene. Carrying a rifle into a building has some downsides – it takes two hands to operate, reducing mobility and versatility, for example – but it also is more accurate and holds rounds that are less likely to over-penetrate, making it a useful tool for a scenario involving uninvolved community members and potential hostages inside a building.

The Training Division Review examined this and understandably concluded that deploying multiple rifles was not necessarily a bad thing, as it gave rifle operators multiple potential angles for firing which could have been critical depending on the position of other individuals in the room.

Commands from Multiple Officers

Multiple officers were shouting commands and warnings at Mr. Elifritz, adding to the chaos and volume in the room. Training for tactical scenarios involving multiple officers instructs that just one officer should give commands, to minimize the possibility of confusion and make it clear to the subject what officers expect him to do. If officers on scene have differing views of what the subject is supposed to be doing in order to demonstrate compliance, officers may develop different impressions of the subject's level of cooperation and have correspondingly different reactions.

Here, the commands were consistent, but having them come from three or four different people might have heightened the level of stress in the room. It is not as though every officer in the room was shouting at Mr. Elifritz; many stated they intentionally stayed quiet because they recognized other officers were giving commands. And many of the commands heard on audio recording of the incident were being given to community members in the room who, for whatever reason, were not uniformly complying with officers' instructions to move away from the subject and out of the room.

Training examined this issue in its review and concluded that part of the problem could be attributed to inconsistent training directives. While teaching that there should be just one command-giver in multiple officer scenarios, the Bureau also emphasizes the need to warn subjects prior to using force. So the less-lethal rifle

operators each felt the need to provide warnings prior to firing on the subject, as other officers also were giving commands. Reexamining this training to clarify the Bureau's expectations was a formal recommendation from Training that was not formally considered or adopted by the Police Review Board.

In our Sixth Report, we recommended that the Bureau develop protocols to ensure that any recommendations made by the Training Division are considered by both the Police Review Board and the Chief (Recommendation 34). We reiterate that recommendation here, while acknowledging that the investigation and review of this incident were completed prior to that report.

K-9 issues

Another aspect that added to the level of chaos in the room was the presence of the police K-9. The K-9 officer had responded to the area to assist with locating Mr. Elifritz. Because of the rain and traffic conditions, officers had not established a perimeter around any of the earlier reported incidents or initiated a K-9 search, but were saturating the area with officers. When officers located Elifritz inside CityTeam, the K-9 officer responded and entered the building with his dog. In his interview with Internal Affairs investigators, he described his reasoning: He believed if all the other people in the room were cleared, and the subject dropped the knife, he would be able to send the dog to control the subject and prevent him from picking the knife back up.

The dog was never released by his officer handler, but his barking can be heard loudly in the midst of officers' commands and all the other noise in the room. Several witnesses (and one grand juror) commented on how the dog's barking contributed to the pandemonium in the room. The Training Division Review did not discuss the use of the K-9 in this situation, or question the officer's reasoning for bringing him into the building. Given the very limited circumstances in which it would have been appropriate to send the dog to bite and control the subject, Training and the other reviewers should have examined whether bringing the K-9 into the building was advisable in this circumstance.

In our Fourth Report, we examined a different shooting incident in which a K-9 deployment raised tactical questions not related to the outcome of the incident. In that case, as here, neither the Training Review, Commander's Review, nor the Police Review Board touched upon the use of the K-9. We recommended then, as now, that the Bureau should evaluate any K-9 presence or use as part of its internal review process.

RECOMMENDATION 15: When a K-9 is present or used in a shooting incident, evaluation of that presence or use should be part of the Training Division Review, Commander's Review and Findings, and Police Review Board discussion.

De-escalation

Part of the standard set of interview questions that Internal Affairs investigators ask after an officer-involved shooting is what, if any, de-escalation techniques the officers employed. In this case, the question prompted a couple of officers to try to come up with an answer for a situation in which other officers recognized that circumstance did not permit tactics that people generally associate with "de-escalation."

Some officers asserted that de-escalation efforts here included using less-lethal projectiles, verbal commands to drop the knife, and an overwhelming show of police. Others defined de-escalation as trying to calm the subject, bond with him, and offer him a solution to the current problem, and asserted that those efforts could not effectively happen until they met their first priority of moving all the bystanders out of harm's way. Most officers effectively cited a number of de-escalation efforts, while also noting that the ideal would have been to isolate Elifritz from the other people in the room, and then slow down and try to communicate with him.

The Bureau's Use of Force directive (1010.00) includes the following provisions on de-escalation:

> *1.1. Members shall use disengagement techniques, when time and circumstances reasonably permit. De-escalation techniques provide members the opportunity to stabilize the scene or reduce the necessity for or intensity of force so that more time, options and resources are available to resolve the confrontation. Members shall take proactive steps to eliminate the immediacy of the threat, establish control and minimize the need for force.*
>
> *1.1.1. De-escalation techniques include, but are not limited to: 1) using verbal techniques to calm an agitated subject and promote rational decision making; 2) allowing the subject appropriate time to respond to direction; 3) communicating with the subject from a safe position using verbal persuasion, advisements, or warnings;*

4) decreasing exposure to a potential threat by using distance, cover, or concealment; 5) placing barriers between an uncooperative subject and an officer; 6) ensuring there are an appropriate number of members on scene; 7) containing a threat; 8) moving to a safer position; and 9) avoiding physical confrontation, unless immediately necessary.

Here, officers did a number of things in addressing Mr. Elifritz consistent with this directive:

- Officers waited at the threshold for a minute and a half, while deploying less-lethal weapons in the hope that Elifritz would give up his weapon.
- Once officers entered the room, they hung back and did not close the distance to Elifritz's position.
- Officers attempted to contain the threat Elifritz posed to others by clearing uninvolved individuals out of the room.
- While as noted above, more than one person was giving commands to Elifritz, many officers were not issuing any commands, and those few officers who were addressing the subject did so in a clear and consistent way.

While neither the Training Division Review nor the Commander's Review was organized around a topic of de-escalation, both discussed all the above factors in the context of the use of force. However, they did not discuss in those documents any alternative strategies the officers might have considered. The officers' duty to protect the many uninvolved individuals in the room certainly limited their ability to slow things down here. There was an understandable and admirable urgency to get into the room and separate Elifritz from the others.

Nonetheless, our reports have repeatedly emphasized the importance of considering alternative scenarios, not with the intent of rendering judgment on decisions made under stress and time pressures, but rather as an opportunity to extract tactical lessons from every critical incident. The observation that "hindsight is 20/20" is sometimes meant dismissively. However, the clarity provided by after-the-fact evaluation can nonetheless be a useful training tool when it comes to a dynamic situation such as this one.

Here, the Bureau's internal analyses could have discussed the possibility of using ballistic shields or creating other barriers between themselves and Elifritz, more aggressively moving to pull the confused or reluctant civilians out of harm's way,

whether a Taser could have been useful in any circumstances, or whether any other measures could have been taken to minimize the chaotic nature of the scene (such as keeping the K-9 out, as discussed above). Again, and as we have noted in discussing other incidents within this Report, the answer may ultimately have been that officers did all that could reasonably be expected. But there is value in asking the question.

Addressing Subjects with Knives

Often, the public's frustration with incidents such as this one stems from the view that officers should be able to control a subject wielding a knife or other edged weapon without resorting to the use of firearms. It is true that distance from a subject with a knife provides a level of safety that the same distance from a subject armed with a gun does not, giving officers more tools and options in these scenarios.

Training personnel in this and other agencies have been grappling with this issue for as long as subjects have had knives. Officers rightly see knives as instruments that have the potential to kill or seriously injure them or others. Any public expectation that officers should be able to aggressively address a subject brandishing a knife and safely overpower or disarm him seems more rooted in Hollywood than real-life scenarios. What the Bureau does do is continually explore innovative tools and new ways of thinking about these issues that might result in different outcomes.

For example, the Training Division has an instructor whose collateral assignment is "Research and Development Officer." Conversations with that officer can range from how European police agencies are experimenting with poles and different distraction methods to control subjects with knives, to new technology in the United States that can wrap subjects up and prevent further advance. He has also become versed in different types of delivery systems for chemical sprays that provide greater accuracy in targeting, new kinds of less lethal rifle rounds, and the status of development of new ballistic vests that that can repel knives as well as bullets.[25]

[25] As a result of our work with and familiarity with other police agencies, we are also aware that some have actually begun beta testing some of the products. See "Digging Deeper: Madison police consider new less-lethal restraint device," https://wkow.com/2019/02/21/digging-deeper-madison-police-considers-new-less-lethal-restraint-device/ ; "LAPD takes a page from Batman, testing device that uses tethers that wrap

All of these potential resources have varying levels of feasibility and applicability in given scenarios, but we encourage the Bureau to continue efforts to identify the strengths and weaknesses of new technology as it looks for new ways to address thorny problems.

Post-Shooting Use of Less-Lethal Weapons

After Mr. Elifritz had been shot and was lying on the ground, the sergeant directed the use of additional less lethal rounds in order to assess whether Elifritz was responsive and thereby to determine whether it was safe for officers to approach. This was a curious decision, given that Elifritz has mostly been impervious to the less-lethal projectiles before he had been shot. The Training Division Review deemed this deployment to be "sound and effective" after simply quoting the officers' interview statements and without any analysis.

Investigation and Review

Review of Video Evidence

Prior to being interviewed, all of the involved officers viewed the cell phone video of the incident that was circulated on social media,[26] as well as some media accounts of the incident.

We wrote about concerns with officers involved in deadly force incidents being permitted to view video of the event prior to being interviewed in our Fifth Report. The Bureau's practice of not showing officers video prior to their interviews is based on the understanding that exposing the officer to video evidence will influence memory and recall in unpredictable ways.

The PPB Detective who testified to the grand jury in this case was questioned about whether the Bureau had, up until that point, released to the public any of the

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suspects' bodies", LA Times December 3, 2019, https://www.latimes.com/california/story/2019-12-03/lapd-new-restraint-device.

[26] This video was recorded by an individual in the shelter who was positioned behind some of the officers. It was uploaded to Twitter on the day of the shooting. Its perspective on the shooting is confusing because the audio and video are not in sync. About 20 seconds before the shooting, the video freezes for several seconds while the audio continues. When you hear the blast of gunfire, it appears as if Mr. Elifritz is standing still. He then takes several steps forward and collapses to the floor.

surveillance videos in its possession. His answer – "Absolutely not." When asked why, he elaborated:

> *We have to protect the integrity of the investigation. So we don't release anything. We keep it all to ourselves. That way when – in a grand jury setting when witnesses come in to testify we know and then you can know that what they're telling you is from their recollection, from their perspective. It's not a video they've seen or an interview they've seen on TV. It's what they know, what they remember. And that's how we protect the integrity of the investigation.*

Because the cell phone video was not in the Bureau's control, however, there was no restriction on the officers' access to it. The Communication Restriction Order issued to each of the involved members the night of the shooting did not forbid them from watching media coverage, though it does discourage it:

> *The purpose of this Communication Restriction Order is to safeguard the integrity of the investigation. A thorough investigation based on each individual's independent recall and perception will lend credibility to each member's testimony and the investigation as a whole. In following this theme, it is strongly recommended that you do not review media coverage or other outside information regarding this incident.*

Despite this recommendation, each of the officers reported that he had watched the video with his respective attorney prior to his Internal Affairs interview. One resolution to this is to amend the Communication Restriction Order to prohibit officers from watching any video of the incident prior to their compelled interview. But the better solution, for reasons stated throughout this report and more explicitly discussed later, would be to interview officers on the night of the incident, before they go home and are exposed to outside media influences, as we have repeatedly recommended.

At a minimum, and in the interim, Internal Affairs should probe the extent to which outside influences – including video and other media – might have impacted an officer's perspective on an incident. Here, each officer interviewed acknowledged watching the video that had been posted on Twitter. Investigators noted this and asked each officer whether their recollection of the incident had been influenced by the video. Each replied, "no" and the investigator asked no further questions.

Cognitive research is clear that an individual's memory of an event will be influenced by watching video of the event, often in subtle ways that the person is not aware of. In those cases where an officer or witness acknowledges having watched video prior to being interviewed, investigators should ask follow up questions regarding the video, to learn, for example, whether the perspective of the video differed from the officer's view of the incident, or whether there was anything in the video that was surprising or that varied from the officer's recollection. Even though the influence of the video may be subconscious, so more specific questions might shed some light on the degree of its impact.

> RECOMMENDATION 16: If an officer has watched video of an incident prior to being interviewed about that incident, Internal Affairs investigators should probe the extent to which that officer's perceptions may have been influenced by the video.

Timeliness of Interviews and Investigation

All of the PPB members who used force (five shooting officers and the two who used the less-lethal shotgun) were interviewed by Internal Affairs investigators on April 9, 2018.[27] The first interview began 37 hours after the shooting, and the lead investigators worked through a 15-hour day to question all seven involved members. As we have stated in earlier reports and throughout this one, these interviews should have been accomplished prior to sending the officers home. Even when the number of shooting officers is significant, it would be preferable to obtain a compressed statement than waiting almost two days to obtain the involved officers' version of what happened.

The Bureau finished its work (investigation and internal review) well within the 180-day timeframe, but it then took three months before the Police Review Board was convened. The case was closed shortly after that hearing.

[27] The one Multnomah County Sheriff's Deputy who fired his weapon during the incident declined to be interviewed by PPB investigators, but did testify to the grand jury.

Grand Jury Issues

Testimony by Training Division Experts

As in other cases discussed in this Report, the District Attorney presented to the grand jury as expert witnesses two Training Division officers, whose testimony unmistakably would lead jurors to conclude that the officers' actions in this incident were consistent with their training.

While in this case, neither officer directly opined on whether the shooting was within policy or legally justified, the practice of having Training Division staff testify to the grand jury about whether an officer's actions and decisions were consistent with training is problematic for the reasons we discuss more fully below.

"Suicide" references

No one in the Police Bureau suggested that Mr. Elifritz's death was inevitable or that he was trying to intentionally engage officers in an attempt to end his life. We have repeatedly talked about this phenomenon and cautioned against using the phrase, "suicide by cop." We were gratified that no one in the Bureau engaged this terminology or mindset in connection with this case.

Unfortunately, the District Attorney raised the issue in questions posed to the medical examiner here:

> Q: Are you familiar with the phenomenon of suicide by the police?
>
> A: Yes.
>
> . . .
>
> Q: Did you consider such a finding in this case?
>
> A: Yes.

The medical examiner then discussed the circumstances in which he would conclude a police shooting was a suicide, and why he would not make such a finding here (because there was no suicide note or express statement of suicidal intent).

We raised this issue in our Sixth Report, in evaluation of an officer-involved shooting in which the medical examiner determined the manner of death to be suicide. We questioned that determination in that case, and similarly question the District Attorney's decision to raise the issue here, despite the absence of the formal determination by the medical examiner. Even raising the possibility to grand jurors that Mr. Elifritz's death could be deemed a suicide could be seen as an effort to obviate any potential criminal culpability for the officers. It is also misleading. While Elifritz's actions could be seen as provoking a police response, they also seem to suggest that he was not someone intent on killing himself (as evidenced by the relatively superficial self-inflicted knife wounds to his neck).

Our concern here is not with the Bureau's performance. Its investigation and review did not suggest that Mr. Elifritz's death was inevitable or the result of his own actions. Of course, how the Medical Examiner and District Attorney conduct their roles in the process are outside of the Bureau's control, but the Bureau has an interest in the integrity of the investigation and its accountability systems that warrants a conversation with its criminal justice partners to discuss the implications of a suicide finding in these circumstances. We recognize that this incident and the resulting grand jury presentation pre-dated our Sixth Report, but nonetheless reiterate the recommendation we made there (Recommendation 15), and expand it to include discussions with the District Attorney.

> RECOMMENDATION 17: The Bureau should initiate a dialogue with the Medical Examiner and District Attorney regarding the potential legal and accountability implications of a finding that a use of deadly force by police officers constitutes a suicide.

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September 30, 2018 ◦ Patrick Kimmons

Sergeant Gary Britt was working Central Precinct on the date of the incident. At 3:02 am, he radioed a request for patrol units to respond to a parking lot. Sergeant Britt later told investigators that the parking lot is adjacent to an establishment that stays open after hours, and there had been a history of disturbances in the area. Britt told investigators that he parked his vehicle, and he and Officer Jeffrey Livingston walked towards a group of individuals congregated on the other side of the parking lot. Britt said that some in the group started fighting as the officers continued to walk toward the crowd, but they had yet to speak to the individuals. Britt stated that one of the individuals, later identified as Patrick Kimmons, raised his arm. Britt observed Kimmons shooting at others[28] and then start moving in the direction of the officers, first running and then "fast walking. " There is no indication that Kimmons observed the officers when he began his flight; it appears coincidental that his path of escape ended up being in their direction.

Sergeant Britt said he drew his firearm, observed a gun in Mr. Kimmons' hand and saw Kimmons place the gun in the waistband of his pants. Britt said he ordered Kimmons to get his hands up. Britt said he then observed Kimmons go to his waistband and start to pull the gun out, at which point Britt fired his gun. Britt said Kimmons stumbled away from him and collapsed. Britt said he used his front sites as he fired aiming at Kimmons' chest. Britt stated that he stopped firing when he noticed that the rounds were having an effect on Kimmons and saw him stumbling and falling to the ground.

Sergeant Britt said when Mr. Kimmons ran toward him, he had no cover as they were exposed in the middle of the parking lot. Britt stated that immediately after he fired, he positioned himself behind a parked car, using the engine block as cover.

Officer Livingston later told investigators that he was working Central Precinct when he responded to Sergeant Britt's radioed request to respond to the parking lot. Livingston said that he met up with Britt and observed a fight break out

[28] It was later learned that two individuals were struck by gunfire from Kimmons' weapon but survived their injuries. The Bureau received little to no cooperation from either victims or witnesses about the shooting's predication.

among a group of individuals. Livingston said that he then saw an individual, later identified as Patrick Kimmons, fire his weapon at the group, back up, and head in the direction of the officers.

Officer Livingston said that he saw a gun in Mr. Kimmons' hand. Livingston then drew his weapon and ordered Kimmons to drop the weapon. Livingston stated that Kimmons continued to move at the officers at a rapid pace, at which time Livingston fired multiple rounds. Livingston said that Kimmons' direction then changed away from the officers. Livingston said that he could see that Kimmons had been struck and had fallen, and that the gun had come out of his hand, at which time Livingston stopped firing.

Responding officers detained Mr. Kimmons and he was transported to the hospital, where he died from his gunshot wounds.

The investigation revealed that Sergeant Britt fired his weapon seven times, while Officer Livingston fired five times. The autopsy revealed that Mr. Kimmons suffered nine gunshot wounds.

- Gunshot wound to right lower leg, back to front
- Gunshot wound to right buttocks, right to left, back to front, and slight downward
- Gunshot wound to right buttocks, right to left, back to front, and downward
- Gunshot wound to left buttocks, left to right, back to front, and downward
- Gunshot wound to left buttocks/flank, right to left, back to front, and downward
- Gunshot wound to left thigh, right to left, downward, exit wound to buttocks
- Gunshot wound to left groin, right to left, downward, bullet recovered from front thigh
- Gunshot wound to left chest, downward, exit wound of left chest
- Gunshot wound to right chest, upward, right to left, bullet recovered from right chest wall

A surveillance video recovered during the investigation showed a group of individuals gathered and then several apparent muzzle flashes. The video further shows Mr. Kimmons running in the direction of two officers. When Kimmons is several feet from the officers, it shows the officers firing their weapons. The

video shows the officers continuing to fire as the individual darts between parked cars and moves away from the officers.

The District attorney presented the case to a grand jury, which concluded that Sergeant Britt and Officer Livingston's actions were legally justified. The Police Review Board recommended an in-policy finding for the use of deadly force.

Timeline of Investigation and Review

9/30/2018	Date of Incident
10/30/2018	Grand Jury concluded
12/12/2018	Internal Affairs Investigation completed
12/20/2018	Training Division Review completed
1/22/2019	Commander's Findings completed
2/27/2019	Police Review Board
3/15/2019	Case Closed

OIR Group Analysis

Review and Tactical Issues

Analysis of the Video and Autopsy Evidence

The Training Division Review found that after Mr. Kimmons fired at the civilian subjects, he placed the handgun into his waistband and quickly began to leave the area. Training found that Kimmons' path of escape led him directly into the path of Sergeant Britt and Officer Livingston. Training found that there was not enough time to move behind cover as Kimmons' approached the officers and found that the officers' actions demonstrated sound and effective tactics. Training

further found that even after Kimmons changed his direction away from the officers, he was still armed with a handgun.

Training did not address the video evidence that apparently shows the involved officers' firing at Mr. Kimmons even after he changed direction and moved away from the officers. Instead, Training's aforementioned observation that Kimmons was still armed seems only to intimate that he continued to present a threat. While this is correct, it is also correct that an armed subject coming towards officers possesses a higher level of threatening intention and ability to aggress than a subject who is running away. Nonetheless, Training does not address this distinction in evaluating the officers' sustained use of deadly force.

The Police Review Board found that the use of deadly force by both officers was within policy. The Board noted that the subject was running towards and not away from the officers as a basis for their determination – a conclusion that was only partially correct in the context of the whole shooting sequence. One Board member opined that the subject received no wounds after he fell to the ground; this was not grounded in either forensic or testimonial evidence. The Board further found that the subject posed an immediate threat to the lives of the officers as well as to the community[29] and that the officers stopped firing once they realized that their rounds had struck the subject and ended the threat.

Officers are universally taught that they are responsible for every trigger pull. In this case, the video and autopsy evidence suggest that during the dynamic event, the threat to the officers changed significantly. When Mr. Kimmons' escape route ended up being in the direction of the officers, his advance on them and apparent extraction of a gun presented a high threat level to them. However, as they began to fire upon Kimmons, that threat level was altered, largely as a result of him abruptly changing direction with his back to the officers and moving away from them. While a fleeing and armed subject remains a threat, the level of threat to the officers is certainly significantly less imminent than a subject who is advancing.

The video evidence clearly shows Mr. Kimmons abruptly shifting direction after the first volley of shots are fired. And it also apparently shows the officers continuing to fire at Kimmons after the shift in direction. While the autopsy evidence, as detailed above, shows two rounds striking his chest, a number of

[29] As we have stated before, a generalized concern for the "community" is insufficiently specific to justify a use of deadly force.

wounds enter Kimmons' body from the side and back, supporting the video evidence that the deadly force continued after he shifted away from the officers.

PPB's Training analysis insufficiently considered how the gradient of threat changed during Mr. Kimmons' encounter with involved officers, concluding that since he was still armed, a threat continued to exist. If a more exacting analysis had been undertaken, the Bureau may have concluded that the initial volley was consistent with expectations, but officers failed to appropriately recognize the reduction in threat level once Kimmons turned away. Alternatively, the Bureau may have determined that there was insufficient time to seek cover during the initial encounter when Kimmons advanced on him, but that officers could have sought cover after he turned away from them. Or the Bureau may have determined that even if the threat level had been somewhat reduced, it was unreasonable to expect the officers to stop firing in the moment, considering the dynamic nature of the event. Regardless, it was incumbent upon the review entities to consider the entire volley of shots, and objectively evaluate the level of threat presented to the officers throughout.

> RECOMMENDATION 18: The Bureau should ensure that its review protocols evaluate the threat level presented to officers during the entire duration of the application of deadly force.

Commander's Review and Findings Memorandum

The Commander's Review and Findings memo in this case contained a simple, rote conclusion without any real application of the facts derived from the investigation to Portland's use of deadly force policy. The Commander simply stated: "After review of the investigative case file and the recommended findings report as written by Internal Affairs Investigator[s], I concur with their recommendation and find that Sergeant Gary Britt and Officer Jeff Livingston actions were within policy."[30]

The "form letter" prepared by the Commander in this case provides no insight to either the Police Review Board or the Chief as to the facts that caused him to recommend an "in policy" finding. As we discuss further below, when a

[30] Identical "form letter" language was used by the Commander in accepting Internal Affairs' "in policy" finding for the actions of the sergeants involved in post-incident responsibilities.

memorandum is so lacking in analysis of these critical incidents, it should be returned to the Commander for additional work.

Supervisory Issues

For several years and to its credit, the Portland Police Bureau has expressly examined decision-making and actions by supervisors involved in ensuring timely medical care to individuals injured by gunfire and other post-incident responsibilities.

In this case, the Training Division Review noted that Sergeant Aaron Schmautz, a non-involved sergeant to arrive on scene believed Sergeant Britt was the field incident commander and only later recognized that Britt had been involved in the shooting. The Training analysis further noted that sergeants were instructed to oversee and supervise the officers involved in taking subjects into custody and not be tactically involved in the operation. Training found that based on the number of officers on scene, Sergeant Schmautz should have remained in his supervisor role. Training found that while the sergeant's actions were consistent with training, they were not the most effective method or tactic.

The Training analysis indicated recognition of a current trend where supervisors had been involved in roles that could and should have been performed by officers. Training noted that it would continue to place emphasis in Critical Incident Management Training that supervisors shall remain in the supervisor role, unless circumstances dictate their need to become tactically involved.

As detailed above, the Commander's Review and Findings memo consisted of a rote acceptance of the recommended findings by the Internal Affairs investigators and did not mention the supervisory issues raised by Training.

The Police Review Board considered the post-incident actions of Sergeant Britt and identified no issues regarding his performance. The majority of the Review Board found that the first responding sergeant also performed consistently with expectations. One Board member noted that, consistent with the Training Division Review, that it was less than optimal for Sergeant Schmautz to be engaged in the detention of Mr. Kimmons and suggested a debriefing of the sergeant. One Board member disagreed with Training and expressed the belief that the Sergeant Schmautz, by getting involved operationally, showed "flexibility and situational awareness."

The Review Board agreed with Training in noting that there was a repeated issue of sergeants directly engaging in operations when arriving on-scene and unanimously agreed to recommend that the issue be systemically addressed by Training. There is no subsequent documentation indicating whether the Training or Review Board recommendation was implemented.[31]

As noted above, the Chief agreed that the supervisory performance of Sergeant Britt was in policy but changed the Review Board finding to require a debriefing focused on the importance of notifying other responding members that he had been involved in the shooting. The Chief further agreed that the actions of the Sergeant Schmautz were in policy but agreed with the minority of the Review Board and ordered a debriefing of that sergeant as well, to discuss the importance of maintaining a supervisory role. Both debriefings were well-documented by the Captain assigned to conduct them.

Action/Reaction Revisited

In this case, the Internal Affairs investigator asked Sergeant Britt whether he had been trained in the action/reaction principle. Britt said that he was trained that there was a delay between what you see and what your brain tells your body to do.

Fortunately, there was no apparent further discussion of action/reaction and subsequent use of the principle to explain and justify the use of deadly force in the Bureau review and analysis.[32] However, consistent with our discussion in the Peeples matter, we recommend that investigators refrain from raising this issue during their interviews of involved personnel.

Prior Use of Deadly Force

Sergeant Britt had been involved in a prior use of deadly force in 2012, a case which we reviewed in a prior report. In that case, we questioned the adequacy of

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[31] In our Sixth Report, we recommended that any systemic issue recommended by the Police Review Board be formally accepted or rejected by the Chief and for those accepted, that a plan for timely implementation be devised. While this review pre-dated our Sixth Report, we remind the Bureau of this recommendation.

[32] Unfortunately, the District Attorney expressly asked the Bureau "expert" about the action/reaction principle in an apparent effort to justify the use of deadly force by the involved officers.

PPB's analysis of then-Officer Britt's tactical decision-making prior to the shooting. In our 2019 Sixth Report, we recommended that the Bureau conduct an executive level review in cases in which officers have been involved in multiple shootings to determine trends and identify potential training issues. The Bureau agreed with and accepted our recommendation at the time. While our Sixth Report post-dated this officer-involved shooting and review, we nonetheless reiterate our recommendation.

Release of Information in Critical Incidents

The Police Review Board unanimously recommended that the Bureau review its policy and practice regarding the timing of the release of information, such as video evidence, to the public following similar incidents. There was no apparent follow up to this recommendation. Certainly, when and whether video evidence of a critical incident should be released to the public is a matter of ongoing discussion throughout the country. Development of written protocols – with input from the public – ensures consistency on release of information and balances the public interest in transparency without compromising the integrity of the investigation. As an increasing number of critical incidents are captured on video, it is incumbent on the Bureau to develop protocols that strike the appropriate balance and move away from ad hoc decisions on whether and when to release information.

> RECOMMENDATION 19: The Bureau should accept the Police Review Board recommendation to develop written protocols, following an opportunity for public input, setting out the parameters for when video evidence of a critical incident is to be released to involved family members and the general public.

Community Outreach

Immediately following the shooting, PPB's Deputy Chief met with community members to listen to their concerns. After the grand jury ruling, the Bureau shared the investigation, including the video, with Mr. Kimmons's family. Additionally, the Chief and her command team met with community members to present the investigation and listen to continued concerns. After the meeting, the Bureau released an investigative summary and videos retrieved as part of the investigation.

This proactive approach to transparency and release of information is in the best tradition of progressive policing. We are hopeful that this becomes routine practice following an officer-involved shooting or other critical incident.

> RECOMMENDATION 20: The Bureau should develop a standard practice of meeting with family members and convening a community meeting within days of an officer-involved shooting or other critical incident to listen to concerns and explain the investigative processes.

Training Staff Testimony to Grand Jury

During the grand jury presentation of this matter, a Bureau officer formerly assigned to the Training Division was asked by the prosecutor whether the use of deadly force by Sergeant Britt and Officer Livingston was consistent with the Bureau's deadly force policy and training. He replied that it was consistent with policy and training.

As in the case involving Mr. Peeples, presenting the testimony of the Bureau officer to the grand jury was problematic for a number of reasons that we discuss more fully below.

Investigative Issues

Use of Video Evidence in Interviews

As noted above, the surveillance video[33] of the incident shows Mr. Kimmons initially moving in the direction of the officers but once officers begin firing, Kimmons moves away from the officers. The video also shows that officers fire additional rounds after Kimmons shifts direction and is no longer advancing toward them.

During the Internal Affairs interview, the surveillance video was not presented to the involved officers and no questions were asked about the sequence captured on camera. While both involved personnel state that Mr. Kimmons does change directions after they shoot him, it is unclear from their statements whether they

[33] Consistent with sound investigative practices, it does not appear that the involved officers previewed the video of the incident prior to being interviewed.

believe they continued to fire after he moved away as the video apparently indicates. The officers were not asked to account for whether the threat presented by Kimmons was different after Kimmons turned away from the officers and moved away from them, nor were they asked to describe the threat they interpreted when they apparently continued to fire as Kimmons turned away.

When video evidence of a critical incident exists, investigative protocols should instruct investigators to obtain a pure statement of the officers' recollection of their observations and actions – as was done here. However, once they give that initial statement, investigators should give the involved officers an opportunity to review video evidence and then question them about events depicted on the video.

> RECOMMENDATION 21: The Bureau should develop protocols to ensure that where a critical incident is captured on video, investigators obtain pure statements from involved officers regarding their observations and actions, and then provide officers an opportunity to review the video of the event followed by subsequent relevant questioning.

Timeliness of Interviews and Investigation

Sergeant Britt and Officer Livingston were interviewed the day after the shooting. While the timing of their interviews is a significant improvement over the intervals discussed in this Report and in past cases, it is still important that protocols be changed so that involved officers' account of the incident be obtained before they are sent home from shift. Until then, the issues of memory contamination and the inability to obtain a "pure statement" from the officer will continue.[34]

This case was completed within the 180-day deadline established in the Bureau's agreement with the U.S. Department of Justice.

[34]At the interview, the attorneys for both Sergeant Britt and Officer Livingston complained that the timing of the interview did not provide the officers sufficient time to prepare for the interview. Britt's attorney reserved the right to supplement the interview when and if details of the incident became either "more clear" or "more accurate." There is no indication that either Britt or his attorney ever found a need to do so.

November 22, 2018 - Richard Barry

This in-custody death involved three public agencies which all had contact with Richard Barry in the half hour or so before his demise – Portland State University Campus Public Safety Office, the Portland Police Bureau and Portland Fire and Rescue/American Medical Response.

Richard Barry was a 52-year old man arrested by members of the Portland State University (PSU) Campus Public Safety Office. A PSU officer had been dispatched to the subject's location at about 8:20 p.m. after the University received several 911 calls indicating that a man was running erratically into the street and screaming for help, saying someone was going to shoot him. The PSU police officer[35] who arrived first on scene attempted to talk to Mr. Barry, who appeared sweaty and agitated, and was running back and forth from sidewalk into the street while yelling about people who were threatening him. The officer called for backup, then attempted to take hold of Barry's arm.

When Portland Police Bureau officers Jared Abby and James De Anda arrived minutes later, Mr. Barry was standing on the sidewalk with his back to the wall of a building as the PSU police officer and three PSU public safety officers tried to control his arms and get his hands cuffed behind him. Officer Abby saw Barry yelling and thrashing his body while the PSU officers were all "breathing very heavily." Two each were holding onto Barry's arms but failing to get him under control. After joining the struggle by also taking one of Barry's arms to get it behind his back, Abby decided that the most successful way to end the struggle quickly was to take Barry to the ground. He got behind Barry and attempted a takedown. Eventually Barry was forced to his knees, then flat on the ground on his stomach. Abby tried to control Barry's head while other officers were still struggling to cuff his hands behind his back. Abby tried unsuccessfully to immobilize Barry's head while Barry continued to struggle, rubbing his head against the concrete and causing abrasions and bleeding.

Officer De Anda had also initially tried to control one of Barry's arms, then assisted with the takedown. He saw Barry go to all fours and tried to push him down further to the sidewalk. When Barry was on his stomach on the sidewalk,

[35] PSU officers are trained and certified by the Oregon Department of Public Safety Standards and Training as peace officers and carry firearms on duty. PSU also employs public safety officers who work with the police officers and do not carry firearms. In this incident, there were three PSU public safety officers and one PSU police officer at the scene.

DeAnda was able to get control of one of his hands and the PSU police officer was able to get both hands cuffed behind his back. DeAnda remained kneeling by Barry's right side and kept his hands on Barry's back until the medical personnel arrived. He felt Barry breathing during this time as well as "slight movement," and believed he was conscious during the period before the ambulance arrived.

When Mr. Barry was handcuffed he continued to protest and yell for help. Officer Abby got up and was going to call an ambulance but learned Acting Sergeant Adrian Matica had already summoned medical assistance while en route to the call. Abby wiped the blood off his pants then returned to Barry, who he observed to be breathing heavily and continuing to make noises. Soon after, though, Abby noticed that he stopped moving and was quiet. Abby assumed that Barry was simply spent because of the struggle. Emergency medical personnel arrived about one minute later and Abby withdrew. DeAnda remained kneeling on the sidewalk near Barry's head.

Sergeant Roger Axthelm and Acting Sergeant Matica had been at the precinct station and heard the broadcast request from University officers. They both responded to the scene. When the sergeants arrived, Mr. Barry was handcuffed on his stomach on the sidewalk with Officer Abby trying to control his head, Officer De Anda kneeling at Barry's right side, and PSU officers trying to control his arms and legs.

Fire and Rescue Bureau and ambulance company paramedics arrived shortly after and Matica directed them right into the scene. Matica noted that even after the paramedics contacted Barry, "there wasn't any exigency in their behavior" or any indication that they were concerned about an evident medical emergency.

The paramedics sat Mr. Barry up and Officer De Anda removed the handcuffs, observing that Barry seemed conscious at this time and noticed no change in the color of his skin. Matica watched as the handcuffs were removed and noticed that Barry still had some tautness in his arms and was growling when paramedics tried to place him in soft restraints on the backboard to go into the ambulance.

As they secured Mr. Barry to the backboard, one of the paramedics stated that Barry was in cardiac arrest. Paramedics monitored his vitals and attempted lifesaving measures before and during transport.

A little over 20 minutes had passed between the arrival of emergency medical personnel and the ambulance's departure with Mr. Barry. He was treated at the hospital for about 18 minutes before being pronounced deceased.

Based on toxicology reports, the Medical Examiner determined that the cause of Mr. Barry's death was acute methamphetamine and cocaine toxicity that adversely interacted with his existing cardiovascular disease. The medical examiner viewed the body camera footage and further determined that the abrasions on Barry's head were not a factor, nor was there a concern about possible asphyxia.

The following chronology of events before Mr. Barry was pronounced deceased is based in part on a body camera worn by the PSU police officer as well as ambulance records and dispatch records:

- A PSU police officer and three public safety officers begin to struggle with Barry standing up against a wall;
- Two and a half minutes later PPB Officers Abby and De Anda arrive on scene and join the struggle;
- Over the next 90 seconds Barry is forced to the ground, handcuffed, and continues to struggle and call for help;
- About 2 minutes later Barry stops speaking or moving in the body cam video;
- 42 seconds later, Portland Fire Bureau and an ambulance from American Medical Response (AMR, a private ambulance company) arrives;
- About a minute after arrival paramedics approach Barry;
- One minute later a paramedic moves some clothing away from Barry's face and wipes it with gauze;
- Four minutes later a paramedic says Barry is in cardiac arrest. They begin lifesaving efforts and load him into the ambulance;
- Barry arrived at the hospital six minutes later with a detectable pulse and respiration but lifesaving efforts failed and he was pronounced deceased 18 minutes after arrival.

The Bureau reviewed the performance of Officers Abby and De Anda for their use of force and Acting Sergeant Matica, Sergeant Axthelm and another sergeant for their scene management and application of death in custody procedures. All actions by PPB personnel were deemed in policy by the Unit Commander, the Police Review Board and the Chief of Police. The Training Division analysis found all PPB officer and supervisor actions to be consistent with training and commented that Officer De Anda employed sound tactics by staying close to Mr. Barry to monitor him after handcuffing.

Several Police Review Board voting members recommending that officers receive additional training for encounters with those experiencing "excited delirium." Because the Board lacked a quorum at the time of this discussion (two advisory members had departed the meeting), the Board could not vote on the recommendation. There is nothing in the file to suggest that the recommendation was nonetheless relayed to the Chief. Though this is an unusual situation not likely to be repeated often, the Bureau should consider developing a formal protocol to address discussions that occur at the Review Board in the absence of a voting quorum.

Timeline of Investigation and Review

11/22/2018	Date of Incident
1/22/2019	Internal Affairs Investigation completed
12/20/2018	District Attorney Prosecution Decline Memo
2/8/2019	Training Division Review completed
2/26/2019	Commander's Findings completed
4/10/2019	Police Review Board
5/16/2019	Case Closed

OIR Group Analysis

Use of Force

The decision to take Mr. Barry into custody and to use force to handcuff him had already been made when the two PPB officers arrived in response to the urgent call for help from PSU campus officers. At the scene they saw four PSU officers struggling unsuccessfully with Mr. Barry, a tall, obviously strong man. They both joined the fray immediately and tried to employ techniques they had recently learned in advanced academy classes. They each stated that their aim was to

conclude the physical conflict as soon as possible with minimum injury. They did not use weapons or blows. This was corroborated by the PSU body camera video (which captured only part of the interaction between PPB personnel and Barry) and by a civilian employee of the university who had followed PSU public safety officers to the scene, in part, because she is a self-described skeptic of police behavior. She observed no use of blows or weapons and remarked upon how relatively gentle officers were.

The PPB Officers did not have an opportunity to make any decisions about the basis for the detention or initial decision to use force. They did not render any first aid to Mr. Barry because each saw no need to, except for his bleeding forehead, which paramedics attended to upon their arrival on scene.

Nevertheless, the officers each used physical force on Mr. Barry and maintained close contact with him during the time he went from loud and combative to static and silent. The supervisors had less time to observe Barry's condition, but Sergeant Axthelm was a trained EMT. This might raise the question as to whether the officers and supervisors were deficient in their training or effort to observe the condition of Barry's health. Yet the emergency medical personnel who arrived within a minute of Barry ceasing to struggle were in close contact with Barry for several minutes before their diagnosis that he was in cardiac arrest. They knew of the recent struggle and noticed nothing that alarmed them. It is difficult to envision an improved training program or field procedure for PPB officers that would be likely to confer on them a skill level that could supersede that of paramedics at the scene.

Timeliness and Inter-Agency Investigation

Both PPB officers who used force on Mr. Barry were interviewed by Internal Affairs two days after the incident, in keeping with PPB practice at the time, but as we have stated, still a significant delay, especially after an incident that attracts media attention which can increase the likelihood of witness exposure to video footage of the incident. Interviewing involved officers before the end of their shift would help safeguard them against exposure to media reports or videos of the incident. Fortunately, the involved officers stated that they had not viewed the PSU body camera video prior to their interviews.

Bureau investigators were never able to interview involved University personnel, however. Internal Affairs investigators sought to interview the PSU police officer and three security officers who initially encountered, detained and handcuffed Mr.

Barry. They declined to respond to repeated requests, even after Internal Affairs complied with their counsel's request to wait until the resolution of the criminal aspect of the incident, signaled by the District Attorney declining, four weeks later, to refer the case to a grand jury.

Incidents of this nature that involve personnel from more than one agency and require investigatory follow-up are common in almost every jurisdiction where multiple agencies operate. Inter-agency cooperation is a well-worn path in Portland, where public safety agencies from Portland, Gresham, Clackamas County, and TriMet, among many others, have overlapping or adjacent duties. PSU should be no exception. In fact, the University calls upon PPB personnel for back up frequently and field personnel appear to cooperate effectively with one another routinely. Additionally, on the rare occasion when a PSU police officer is involved in a shooting, the University requests that Bureau detectives handle the criminal investigation. This relationship should provide ample basis for Bureau leadership to discuss the future of PSU public safety personnel cooperation with PPB's Internal Affairs investigators.[36]

This is not just a matter of procedural principle. Despite the body camera footage from the PSU police officer, it is critical for a thorough investigation to learn the observations and actions of all personnel at the scene including the beginning of the physical struggle with Mr. Barry and his appearance and condition during and after the struggle. If there were no body camera video, it would be all the more vital to have their statements. That interest is particularly acute in this case since the District Attorney declined to convene a grand jury and there is no evidence that PSU conducted its own administrative investigation.

Equally disappointing, if less surprising (because it happens frequently), was the complete lack of response by the emergency medical services personnel to Internal Affairs investigators' request for interviews. Both Portland Fire Bureau and the private ambulance company which contracts with the city and county had provided emergency medical response or support in this incident. Internal Affairs served subpoenas issued through the City Auditor's Independent Police Review (IPR) office's authority under the City Code (Section 3.21.210) to the two EMTs

[36] By law and policy, PPB supervisors may order PPB sworn officers to submit to questioning by Internal Affairs conducting an administrative investigation or be subject to discipline. (This situation is distinct from questioning by detectives conducting the criminal investigation where officers may invoke their Fifth Amendment right to remain silent without fear of discipline.) When an officer submits to a compelled interview with Internal Affairs, his or her answers cannot be used in a criminal prosecution without his or her consent. These principles should apply equally to PSU safety personnel.

who put Mr. Barry in their private ambulance. The subpoenas were ignored, as were the phone messages that Internal Affairs left with Portland Fire.

The fact that the subpoenas were ignored and there was no apparent attempt to enforce them calls into question the efficacy of IPR's subpoena authority. If that authority is to have teeth, entities that ignore issuance should face consequences for non-compliance. In this case, the failure of the subpoenas to gain cooperation suggests a need to re-examine the subpoena enforcement process.

> RECOMMENDATION 22: Bureau executives and City representatives should meet with Portland State University leadership with the aim of agreeing upon written procedures that would ensure the cooperation of field personnel with all investigations conducted by Bureau Detectives and Internal Affairs investigators.
>
> RECOMMENDATION 23: Bureau executives and City representatives should convene a meeting with Portland Fire Bureau and American Medical Response leadership to develop written protocols to ensure that City departments and contractors cooperate with the Bureau's criminal and internal investigations.
>
> RECOMMENDATION 24: The City should ensure there is an effective enforcement mechanism for defiance or non-compliance with IPR's subpoena authority.

Effective Preservation of Evidence

Acting Sergeant Matica first became aware that there was a medical emergency when Mr. Barry was strapped to a backboard by the medics in preparation for placing him in the ambulance. The medics said their patient was in cardiac arrest. Hearing this, Sergeant Axthelm notified his colleagues that the scene was now potentially a crime scene and he and Matica, along with another sergeant who had just arrived, Sergeant Robin Dunbar, quickly divided supervisory tasks and told the involved officers to stop removing any blood from their clothing or hands and to tape off the area. Axthelm followed the ambulance to the hospital, Dunbar controlled the scene and physical evidence, and Matica began interviewing witnesses. Officers Abby and De Anda were separated, admonished and placed in separate cars and provided with chaperones as other PPB officers arrived.

These actions show a clear understanding of the Bureau's expectations at a crime scene and effective cooperation among the field supervisors. This benefits any investigation by "freezing" the scene at an early stage and preserving objects, vehicles, blood stains or their positions.

Commander's Review and Findings

The Commander's Review and Findings memo in this case was devoid of any expressed analysis or observations about the facts. The Commander may have found the case uncomplicated or the performance of the personnel in question uncontroversial, but there is no indication of that or any other guidance provided to the Police Review Board and Chief beyond the bare boiler plate language.

The Bureau's Internal Affairs and Training Divisions, the Responsibility Unit Commander, with the concurrence of the Police Review Board and the Chief, all concluded that PPB personnel adhered to Bureau policies and procedures. However, as we discuss further below, when a Commander submits a report that contains no analysis or application of the facts to Bureau expectations, it messages an unfortunate lack of interest or understanding of the need for an exacting review following an in-custody death.

SECTION TWO

Common Themes and Issues

Considering Alternative Scenarios

A theme that we have repeated over the years of our work in Portland (as well as numerous other jurisdictions) is the importance of acknowledging that there are lessons to be learned in every critical incident. We have frequently been impressed with the thoroughness of the Bureau's investigative protocols and their multi-layered internal review. We also regularly note examples of significant concerns that have been overlooked. The problem may be rooted in a tension between two fundamental questions: Was the shooting in policy? and What could we do better next time? The Bureau's review model emphasizes the first question, but does not impose any requirement to explore the second question. The question about policy compliance is, of course, vital to determine whether discipline, remedial training or other action is called for, but the question about "next time" is how a learning organization completes a truly constructive internal analysis.

Acknowledging that an officer might have approached a situation differently, deployed another tool, communicated more effectively, recalcluated his or her risk assessment, or made a different tactical decision does not necessarily undermine a finding of justifiable use of force. Unfortunately, the consideration of alternative scenarios is too often seen as unfair, after-the-fact criticism of an

officer's performance instead of a constructive attempt to improve the ways in which officers approach and resolve problems.

We have presented this theme in various ways, through commentary and recommendations across numerous reports. While again, we have often been impressed by the analysis conducted by Portland's review process, we still see instances where the focus on the decision about whether a shooting is "in policy" cuts short the type of evaluation of officer decision making demanded of these critical incidents. For example:

- In the case involving Mr. Peeples, neither the Training Division Review, the Commander's Review, nor the Police Review Board identified one issue or advanced one question about the risk assessment or decision making of the involved officers that led to the shooting of an unarmed man.

- In the shooting involving Ms. Brown, reviewers did not fully address the question of whether responding officers could have engaged in further planning before opening the structure in which Brown was hiding, and whether they could have positioned themselves differently and exercised greater patience in confronting the subject.

- In assessing the way in which officers confronted Mr. Elifritz, reviewers did not discuss the possibility of using shields or barriers, or ways to minimize the level of noise and chaos that everyone noted as an obstacle to more effective communication with the subject.

- When discussing the apprehension of Mr. Brockner, reviewers did not assess how the acknowledged lapses in the officers' communication may have contributed to Officer Staab's threat assessment and ultimate decision to use deadly force.

In our review of hundreds of shootings, we have yet to find one where the response and decision-making was not worthy of critical analysis and consideration of other possible scenarios and outcomes. And even if the evaluation concludes there was nothing the involved officers could have done better, engaging in the analysis and considering alternative approaches is a worthy endeavor.

We know from our experience working with the Bureau's leaders that the agency prides itself on fostering a culture that promotes continuous growth and learning. We have seen numerous examples of that over the course of our work on PPB critical incidents. Nonetheless, it is our job to note the Bureau's lapses in this regard, and to make recommendations to promote further growth and consistency. Past reports have recommended that the Commander and Police Review Board make explicit findings regarding pre-shooting tactical decision-making. (Fifth Report, Recommendation 20; Sixth Report, Recommendation 34). Full implementation of these recommendations would promote the analysis of alternative possible scenarios we envision here. We encourage the Bureau to continue to work toward this goal with the lessons of the cases discussed in this report as further motivation.

Grand Jury Testimony of Training Division Staff

During all three of the shootings in which a grand jury was convened following incidents discussed in this report, the District Attorney's office called Bureau officers assigned to the Training Division to serve as expert witnesses on the question of whether the officers' use of deadly force was consistent with Bureau training. In all three, the Training Division officers concluded that the use of deadly force was consistent with training. In two of the cases, the witnesses were asked their opinion about whether the shooting was within Bureau's use of deadly force policy. In all cases, the officers provided expert testimony that essentially exonerated the involved officers.

While Bureau training and policies on the use of deadly force are relevant to an officer's state of mind in a criminal context, the testimony of the Bureau officers in the grand jury presentations of these cases was premature and based on an incomplete record. Expert witnesses are generally provided a full investigative file upon which to base their opinions. In the cases involved here, though, there is no evidence that the Training officers had any opportunity to review the investigative materials in the relevant cases.

Even if the officers had been provided with the complete criminal investigative files, it was inappropriate for a Bureau officer assigned to the Training Division to opine about the propriety of a shooting before the administrative investigation had been completed. The analyses of the shootings by the Commander and by the officer's own Training Division had not been completed. And under Bureau

protocols, even the Training Division supervisor assigned to conduct the Training analysis may conclude whether the officer's actions were consistent with training, but does not determine the ultimate question: whether a particular use of deadly force was within policy. That decision is left to the Police Review Board, which makes a recommendation to the Chief for the final determination.

The Bureau cannot control who the District Attorney calls to the grand jury but could work with its criminal justice partner to explain the difficulties with engaging its Training staff to render an opinion on the propriety of the shooting. Even if the District Attorney insists on calling Training officers, they should indicate they are not authorized to opine on the ultimate question because the administrative investigation had not been completed and the decision on whether deadly force was within policy rested with their Chief.

> RECOMMENDATION 25: The Bureau should direct its Training Division staff and other members to refrain from opining about the appropriateness of the use of deadly force in any forum, including grand jury proceedings, until that administrative determination has been made by the Bureau.

Commanders' Review and Findings

The Bureau's multilayered internal review system for critical incidents provides a clear, well-documented dialogue that culminates in the Police Review Board findings and the Chief's final decision. The role of the Responsibility Unit Manager (generally a member at the rank of commander) is a key element of the process. The Bureau's process requires the Commander to review the investigative file and produce a memorandum documenting his or her findings, to be presented to the Police Review Board.[37]

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[37] Portland Police Bureau directives set out the responsibilities for the Commander who has supervisory authority over the involved officers:

> 6.8.1. The RU manager shall utilize [Professional Standard Division's] investigation materials to draft a findings memorandum to determine whether member actions were within policy. These findings shall be presented to the [Police Review Board].

Historically, the Commanders' findings memos are wide-ranging and unconstrained by a rigid report format. They are intended to distill the most important aspects of an incident and make recommendations as to whether the Bureau's employees have complied with policy. In addition, Commanders typically make recommendations as to whether discipline, training or other remedial measures are an appropriate response to the incident, and they identify or comment on systemic issues.

The Commander provides a vital link between the investigation and the ultimate adjudication of the Bureau's review process. The Commander has the entire investigative file to draw upon including all interviews, scene photos and forensic evidence. Additionally, he or she reviews the analysis by the Training Division's experts and the grand jury transcript, if there is one. The Commander is also in the direct line of supervision over the involved officers and supervisors and may be well acquainted with each officer's capabilities or history of challenges or problems in the field. Moreover, as executive officers, the Commanders have an understanding of Bureau priorities and initiatives. If the Chief orders disciplinary action, a debriefing or training, it will be within the Commander's responsibilities to ensure completion.

In our work with Portland, we have reviewed numerous memoranda prepared by Commanders and, while we at times have pointed to issues we thought the Commander may have overlooked or disagreed with their analysis, we have often found them to be well-reasoned, thorough, and thoughtful in analyzing the evidence and the relevant policies. Some Commanders have effectively used the opportunity to comment upon relevant issues that may go beyond those presented in the case before them and focus on problems with the Bureau's communications systems, equipment or the manner in which policies are applied in the field.

We commend the process and those Commanders whose review and findings memos contributed to the constructive dialogue that is important to the post-incident review process.

In the group of seven cases discussed in this report, however, two of the Commander's memoranda were devoid of any analysis or observations about the facts of the incident, the choice of strategy, tools, and weapons in the field, the communication of officers, the choices and capabilities of supervisors, the attention to medical care for the injured, the preservation of the scene and the integrity of the physical evidence, or the observations of the participants and witnesses. In those two cases (Kimmons and Barry), the Commander's

memoranda were no more than a boiler plate format with little more than a rubber-stamped finding. [38]

These memos were striking because they veered so far from the norm and, in our view, represented a lost opportunity. In the review of both the Kimmons and Barry incidents, the Commanders' Review and Findings memos were devoid of any expressed analysis or observations about the facts and made the perfunctory conclusions that all the involved officers' actions were within policy, the post-shooting procedures met Bureau expectations and there was nothing to be learned from the incidents. That conclusion in Kimmons was particularly striking in light of the post-incident shooting issues identified in the Training Division Review. In short, the two memoranda we identified did not advance the important interests of the Bureau's internal review process and instead amounted to cursory reviews of incidents that ended in the deaths of two individuals.

The Bureau should build into its review process a system of checks and balances so that when a Commander submits a findings memorandum that contains no analysis or application of the facts to Bureau expectations, the memo is returned for additional work to bring it up to standards.

> RECOMMENDATION 26: The Bureau should make clear its expectations for the Responsibility Unit Manager's assessment of a critical incident, and when the Review and Findings memorandum does not meet those expectations, the Commander should be instructed to make necessary revisions.

Timeliness of Involved Officer Interviews

In the cases analyzed in this report, Internal Affairs investigators generally interviewed involved officers within a day or two of the incidents. While this delay is a significant improvement over the sometimes weeks and months it took before involved officers were interviewed in prior cases we have reviewed, two

[38] In March 2018, Internal Affairs investigators began including recommended findings in their investigative reports. It may be more than coincidence that the two Commanders' memoranda we found lacking in analytical detail both were written after that date. With prior findings to refer to, it becomes easier for a Commander so inclined to simply cite to those findings and conduct no further analysis. However, the expectation is and should be that a Commander has a broader responsibility than merely relying on prior recommendations as his or her "analysis."

days is still too long to wait to obtain an account from the individual most knowledgeable about the use of deadly force, the shooting officer him or herself.

We have written on this subject repeatedly in our years working with Portland and have seen significant evolution in the City and the Bureau's thinking on this issue. A couple of cases we report on here, however, demonstrate the importance of interviewing officers on the night of the incident, as we have repeatedly recommended.

In the incident involving Mr. Peeples, the Bureau released a statement to the media about the incident that included significant details derived from the interview of a non-shooting officer provided within hours of the incident. While it is unclear whether Officer Reagan read this account or to what extent it might have impacted his own account of the incident, best investigative practices demand that witnesses be interviewed prior to any possibility of contamination from other sources.

The delay in interviewing the officers involved in the shooting of Mr. Elifritz had potentially more significant consequences. There, a witness made a recording of the shooting on his cell phone and uploaded it to Twitter that same night. Though Internal Affairs investigators began their interviews 37 hours after the shooting, each of the officers reported that he had watched the video with his respective attorney prior to his interview. While all said that seeing the video did not impact their recollection of the event, cognitive research is clear that an individual's memory will necessarily be influenced by watching video of an event, often in subtle, subconscious ways.

As society's demand for constant access to news sources and reliance on social media grows, the ability to preserve the integrity of investigations diminishes and the need for more timely officer interviews intensifies.

> RECOMMENDATION 27: The Bureau should change its officer-involved shooting protocols to require all officers who use deadly force are interviewed before the end of their shifts.

Timeliness of Investigations

The Bureau's agreement with the United States Department of Justice requires it to complete the investigative and review process of officer-involved shootings within 180 days.

The table below depicts all of the incidents that have occurred since the Bureau's agreement with the Justice Department to complete its investigation and review process within 180 days, plus the incident involving Mr. Davis, which occurred just prior to finalization of the agreement. The shaded rows are the officer-involved shootings covered in this report. The trend we noted in our past report, where the Bureau complied with the 180-day deadline in the majority of incidents reviewed, has unfortunately not carried through to the cases we reviewed in this report.

In the cases reviewed for this report, only two were completed within this timeframe. There was no single apparent hang-up that repeatedly caused delays. In one case, the Training Division Review took longer than usual. In another, there was a delay in scheduling the case to be heard by the Police Review Board. Two lengthy delays were seemingly the result of administrative oversight, as the cases languished for months without being formally signed off and closed by the Chief's office.

In each case that extends beyond the 180-day deadline, the Bureau should ensure that it identifies the cause of the delay, evaluates any potential fixes, and documents these efforts.

> RECOMMENDATION 28: When the investigation and review of an officer-involved shooting extends beyond the 180-day deadline established in the Bureau's agreement with the U.S. Department of Justice, the Bureau should identify the cause of the delay, evaluate potential remedial measures, and fully document these efforts.

Timing to Completion of Investigation and Review

Subject's Name	Date of Incident	Time to Case Closure
Richard Barry	11/22/2018	175 days
Patrick Kimmons	9/30/2018	166 days
John Elifritz	4/7/2018	250 days
Sarah Brown	3/8/2018	252 days
Chase Peeples	10/27/17	239 days
Jesse Brockner	8/30/2017	342 days
Michael Grubbe	5/28/2017	242 days
Terrell Johnson	5/10/2017	237 days*
Don Perkins	2/9/2017	151 days*
Quanice Hayes	2/9/2017	155 days*
Steven Liffel	12/5/2016	185 days*
Timothy Bucher	5/24/2016	155 days*
Michael Johnson	11/6/2015	173 days*
David Ellis	7/5/2015	138 days*
Alan Bellew	6/28/2015	158 days*
Michael Harrison	5/17/2015	155 days*
Christopher Healy	3/22/2015	149 days
Ryan Sudlow	2/17/2015	321 days
Denoris McClendon	9/1/2014	189 days*
Nicholas Davis	6/12/2014	188 days

* These times have been amended from those published in prior reports, to be consistent with the method of calculation used by IPR and the Bureau and to reconcile with IPR and Bureau databases about which we were previously unaware. Our prior practice calculated days based on closure dates that were earlier than what was formally approved in the settlement agreement with the Department of Justice.

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SECTION THREE Recommendations

1 The Bureau should routinely refer officers for firearms training that includes stress recognition and reduction after any incident involving firearms use that indicates misperception of target or surroundings.

2 The Bureau should meet with leadership from the District Attorney's Office and the Community Mental Health Director to explore compassionate solutions to the problem of arrested persons who will be released without charge but are determined to be in mental health crisis and in need of further evaluation and/or treatment.

3 During critical incident reviews, whenever a Bureau-initiated tactic or frequently-used technique does not produce the desired results (such as when a subject escapes from a containment perimeter), the Bureau should conduct an analysis with the objective of improving those tactics and techniques in future incidents.

4 The Bureau's review process should examine an officer's use of profanity when confronting a subject, assess the totality of the circumstances, and determine whether the language used was consistent with the Bureau's expectations.

5 The Bureau should ensure that Training Division Reviews consider whether officers articulated a plan, and whether any failure to do so was consistent with training under the circumstances.

6 In officer-involved shooting reviews, the Bureau should assess the risk calculation of involved officers, and when appropriate provide additional training on how best to assess that risk.

7 Whenever evidence is moved at a crime scene, the investigation and analysis should consider whether there were alternative methods to accomplish post-incident objectives.

8 Whenever involved officers are also assigned a post-incident tactical role, the investigation and analysis should consider whether it was necessary to assign them such a role.

9 The Bureau and Police Review Board should ensure that officer-involved shooting reviews do not begin and end with a citation to the action-reaction principle but must critically assess other tactical options that might have driven a different result.

10 Bureau officer-involved shooting protocols should be modified to require routine discussion and analysis regarding any decision by officers not to call or wait for additional officers to arrive before tactically engaging a subject.

11 The Bureau should develop protocols to ensure that the Bureau's Behavioral Health Unit's resources are not used for a purpose inconsistent with its mission.

12 The Bureau should modify its protocols so that investigators are tasked with either collecting medical and toxicological evidence in cases where individuals are injured but not killed in police shooting, or documenting their inability to do so.

13 When Bureau officers attempt to breach the entrance to an opaque closed structure with subjects inside, this is a high risk encounter and investigators and reviewers – including Internal Affairs, Training, and the Commander – should explore and consider whether safer tactical alternatives existed to forcing the entrance open. This would include considerations of (1) whether the arrest team could take safer positions or employ mobile cover such as ballistic shields before opening the entrance; and (2) whether it would be practical and prudent to delay forcing the entrance until the arrival of SERT and crisis negotiators.

14 The Bureau should emphasize alternative ways to approach an armed or possibly armed subject, as well as options for improving cover and explore these issues as a component of the analyses performed by its subject expert internal reviewers, specifically the Commander's Review and the Training Division Review. This component would be most effective if stated separately from the policy determination.

15 When a K-9 is present or used in a shooting incident, evaluation of that presence or use should be part of the Training Division Review, Commander's Review and Findings, and Police Review Board discussion.

16 If an officer has watched video of an incident prior to being interviewed about that incident, Internal Affairs investigators should probe the extent to which that officer's perceptions may have been influenced by the video.

17 The Bureau should initiate a dialogue with the Medical Examiner and District Attorney regarding the potential legal and accountability implications of a finding that a use of deadly force by police officers constitutes a suicide.

18 The Bureau should ensure that its review protocols evaluate the threat level presented to officers during the entire duration of the application of deadly force.

19 The Bureau should accept the Police Review Board recommendation to develop written protocols, following an opportunity for public input, setting out the parameters for when video evidence of a critical incident is to be released to involved family members and the general public.

20 The Bureau should develop a standard practice of meeting with family members and convening a community meeting within days of an officer-involved shooting or other critical incident to listen to concerns and explain the investigative processes.

21 The Bureau should develop protocols to ensure that where a critical incident is captured on video, investigators obtain pure statements from involved officers regarding their observations and actions, and then provide officers an opportunity to review the video of the event followed by subsequent relevant questioning.

22 Bureau executives and City representatives should meet with Portland State University leadership with the aim of agreeing upon written procedures that would ensure the cooperation of field personnel with all investigations conducted by Bureau Detectives and Internal Affairs investigators.

23 Bureau executives and City representatives should convene a meeting with Portland Fire Bureau and American Medical Response leadership to develop written protocols to ensure that City departments and contractors cooperate with the Bureau's criminal and internal investigations.

24 The City should ensure there is an effective enforcement mechanism for defiance or non-compliance with IPR's subpoena authority.

25 The Bureau should direct its Training Division staff and other members to refrain from opining about the appropriateness of the use of deadly force in any forum, including grand jury proceedings, until that administrative determination has been made by the Bureau.

26 The Bureau should make clear its expectations for the Responsibility Unit Manager's assessment of a critical incident, and when the Review and Findings memorandum does not meet those expectations, the Commander should be instructed to make necessary revisions.

27 The Bureau should change its officer-involved shooting protocols to require all officers who use deadly force are interviewed before the end of their shifts.

28 When the investigation and review of an officer-involved shooting extends beyond the 180-day deadline established in the Bureau's agreement with the U.S. Department of Justice, the Bureau should identify the cause of the delay, evaluate potential remedial measures, and fully document these efforts.

Appendix

Table of Critical Incidents Reviewed by OIR Group

2004 – 2018

Subject's name	Date	# of involved/ shooting officers	# of rounds fired	Officers' weapon(s)	Hit/ non-hit	Fatal/ non-fatal	Subject weapon?	Subject's Race	Mental health issues	Officer(s) disciplined?
James Jahar Perez	3/28/04	1	3	9mm	Hit	Fatal	Unarmed	African-American	No	No
Marcello Vaida	10/12/05	2	38	9mm	Hit	Non-fatal	Handgun	African-American	No	No
Raymond Gwerder	11/4/05	1	1	AR-15	Hit	Fatal	Handgun	White	Yes	No
Dennis Lamar Young	1/3/06	1	2	9mm	Hit	Fatal	None (subject drove vehicle at shooting officer)	White	No	Yes[a]
Timothy Grant	3/20/06	1	N/A	N/A	N/A	In-custody death	N/A	White	No	No
Jerry Goins	7/19/06	1	4	9mm	Hit	Fatal[b]	Handgun	White	Yes	No
Scott Suran	8/28/06	1	2	AR-15	Hit	Non-fatal	None	White	No	No
James Chasse	9/17/06	3	N/A	N/A	N/A	In-custody death	N/A	White	Yes	No
David Earl Hughes	11/12/06	3	15	9mm (2); AR-15 (1)	Hit	Fatal	None	White	Yes	No
Dupree Carter	12/28/06	1	2	9mm	Non-hit	Non-fatal	Handgun	African-American	No	No
Steven Bolen	5/22/07	2	10	9mm; AR-15	Hit	Fatal	Shotgun	White	No	No
Leslie Stewart	8/20/07	1	1	AR-15	Hit	Non-fatal	None	African-American	No	No
Jeffrey Turpin	10/5/07	1	4	9mm	Hit	Fatal	Handgun	White	Yes	No
Jason Spoor	5/13/08	2	2	9mm	Hit	Fatal	Handgun	African-American	Yes	No
Derek Coady	5/15/08	1	2	9m	Non-hit	Fatal[d]	Handgun	White	Yes	No
Osmar Lovaina-Bermudez	8/24/09	1	3	AR-15	Hit	Non-fatal	Handgun	Latino	No	No
Aaron Campbell	1/29/10	1	1	AR-15	Hit	Fatal	None	African-American	Yes	Yes[e]
Jack Dale Collins	3/22/10	1	4	9mm	Hit	Fatal	Knife	White	Yes	No

Table of Critical Incidents Reviewed by OIR Group

2004 – 2018

Subject's name	Date	# of involved/ shooting officers	# of rounds fired	Officers' weapon(s)	Hit/ non-hit	Fatal/ non-fatal	Subject weapon?	Subject's Race	Mental health issues	Officer(s) disciplined?
Keaton Otis	5/12/10	2	19-21	9mm	Hit	Fatal	Handgun	African-American	Yes	No
Craig Boehler	11/23/10	1	3	AR-15	Hit	Fatal[f]	Handgun and rifle	White	No	No
Darrryll Ferguson	12/17/10	2	20	9mm	Hit	Fatal	Replica handgun/ BB gun	White	No	No
Marcus Lagozzino	12/27/10	1	4	AR-15	Hit	Non-fatal	Machete	White	Yes	No
Kevin Moffett	1/1/11	1	1	9mm	Non-hit	Non-fatal	Handgun	African-American	No	No
Thomas Higginbotham	1/2/11	2	12	9mm	Hit	Fatal	Knife	White	Yes	No
Ralph Turner	3/6/11	2	4-5; then cover fire	9mm; AR-15	Non-hit	Non-fatal	Rifle, shotgun, and handgun	White	Yes	No
William Kyle Monroe	6/30/11	1	4	Less-lethal shotgun loaded with lethal rounds	Hit	Non-fatal	None	White	Yes	Yes
Darris Johnson	7/9/11	3	N/A	N/A	N/A	In-custody death	N/A	African-American	No	No
Brad Lee Morgan	1/25/12	2	5	9mm	Hit	Fatal	Replica handgun	White	Yes	No
Jonah Aaron Potter	3/26/12	4	7	9mm (2); M4 (1); M16 (1)	Hit	Non-fatal	Replica handgun/ BB gun	White	Yes	No
Juwan Blackmon	7/17/12	1	1	9mm	Hit	Non-fatal	Handgun	African-American	No	No
Billy Wayne Simms	7/28/12	1	6	AR-15	Hit	Fatal	Handgun (unloaded)	White	No	No

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Michael Tate	8/21/12	1	2	9mm	Non-hit	Non-fatal	None (subject raised hand holding cell phone)	Latino	Yes	No
Joshua Baker	9/29/12	2	17	9mm; AR-15	Hit	Non-fatal	Rifle	White	Yes	No
Merle Hatch	2/17/13	3	19	9mm (2) AR-15 (1)	Hit	Fatal	None (subject pretended telephone receiver was a handgun)	White	Yes	No
Santiago Cisneros	3/4/13	2	22	9mm	Hit	Fatal	Shotgun	Latino	Yes	No
Kelly Swoboda	3/12/14	1	4	9mm	Hit	Fatal	Handgun	White	No	No
Paul Ropp	4/16/14	2	15	9mm	Hit	Non-fatal	Rifle	White	No	No
Nicholas Davis	6/12/14	1	2	9mm	Hit	Fatal	Crowbar	White	Yes	No
Denoris McClendon	9/1/14	1	2	Shotgun	Hit	Non-fatal	Replica handgun/ BB gun	African-American	Yes	No
Ryan Sudlow	2/17/15	1	1	9mm	Non-hit	Non-fatal	None	White	No	No
Christopher Healy	3/22/15	1	2	9mm	Hit	Fatal	Knife	White	Yes	No
Michael Harrison	5/17/15	1	7	9mm	Hit	Non-fatal	Knife	White	Yes	No
Alan Bellew	6/28/15	2	14	9mm	Hit	Fatal	Replica handgun/ starter pistol	White	No	No
David Ellis	7/5/15	1	1	9mm	Hit	Non-fatal	Knife	White	Yes	No
Michael Johnson	11/6/15	2	7	M4 rifle	Hit	Fatal	Handgun	White	Yes	No

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Timothy Bucher	5/24/16	2	16	M4 rifle; .223 rifle	Non-hit	Non-fatal	Assault rifle and handgun	White	Yes	No
Steven Liffel	12/5/16	1	1	AR-15	Hit	Fatal	Rifle and handgun	White	Yes	No
Quanice Hayes	2/9/17	1	3	AR-15	Hit	Fatal	Replica handgun	African-American	No	No
Don Perkins	2/9/17	2	10	AR-15; 9mm	Hit	Non-fatal	Replica handgun	White	Yes	No
Terrell Johnson	5/10/17	1	4	9mm	Hit	Fatal	Knife	African-American	No	No
Michael Grubbe	5/28/17	3	15	Shotgun (2) 9mm (1)	Non-hit	Non-fatal	Replica handgun/ BB gun	White	Yes	No
Jesse Brockner	8/30/17	1	3	9mm	Hit	Non-fatal	Handgun	White	No	No
Chase Peeples	10/27/17	1	6	9mm	Hit	Non-fatal	None	African-American	Yes	No
Sarah Brown	3/8/18	2	30	9mm; AR-15	Hit	Non-fatal	Handgun	White	Yes	No
John Elifritz	4/7/18	5 PPB officers; 1 MCSO deputy	17	AR-15 (3) handgun (2) shotgun (1)	Hit	Fatal	Knife	White	Yes	No
Patrick Kimmons	9/30/18	2	16	9mm	Hit	Fatal	Handgun	African-American	No	No
Richard Barry	11/22/18	2	N/A	N/A	N/A	In-custody death	N/A	White	Yes	No

---------Reviewed in OIR Group's Report Concerning the In-Custody Death of James Chasse, July 2010
---------Reviewed in OIR Group's Report on Portland Police Bureau Officer-Involved Shootings, First Report, May 2012
---------Reviewed in OIR Group's Report on Portland Police Bureau Officer-Involved Shootings, Second Report, July 2013
---------Reviewed in OIR Group's Report on Portland Police Bureau Officer-Involved Shootings, Third Report, November 2014
(no shading) Reviewed in OIR Group's Report on Portland Police Bureau Officer-Involved Shootings, Fourth Report, January 2016
---------Reviewed in OIR Group's Report on Portland Police Bureau Officer-Involved Shootings, Fifth Report, February 2018
---------Reviewed in OIR Group's Report on Portland Police Bureau Officer-Involved Shootings, Sixth Report, January 2019
---------Reviewed in OIR Group's Report on Portland Police Bureau Officer-Involved Shootings, Seventh Report, April 2020

[a]The Bureau made the decision to terminate the shooting officer. The decision was overturned by the Arbitrator, and he was instead suspended for 30 days.
[b]After being struck by the officer's gunfire, Mr. Goins raised his gun to his own head and shot himself. The Medical Examiner ruled the cause of death to be suicide.
[d]After both of the officers' shots missed, Mr. Coady shot himself in the head. The Medical Examiner ruled the cause of death to be suicide.
[e]The Bureau made the decision to terminate the shooting officer. The decision was overturned by the Arbitrator, and that decision was confirmed on appeal.
[f]None of three rounds fired were deemed fatal, but Mr. Boehler died of smoke inhalation in the ensuing fire in his house.

RESPONSE TO THE REPORT

CITY OF PORTLAND, OREGON

Bureau of Police
Ted Wheeler, Mayor
Jami Resch, Chief of Police
1111 S.W. 2nd Avenue • Portland, OR 97204 • Phone: 503-823-0000

Integrity • Compassion • Accountability • Respect • Excellence • Service

March 25, 2020

Mary Hull Caballero
City Auditor
1221 SW 4th Avenue, Room 140
Portland, OR 97204

Dear Auditor Hull Caballero:

Thank you for the opportunity to review and respond to the OIR Group's seventh report regarding seven officer-involved shootings from May 28, 2017 – November 22, 2018.

While the Police Bureau has made significant changes to its directives, procedures and training over the last few years, we are committed to reviewing and updating when necessary. As you will note in our response, we agree with the majority of recommendations outlined by the OIR Group in this report. I'm pleased to report many of the recommendations are already current practice.

We appreciate the work of the OIR Group, as this additional layer of transparency is important to further understand and review these traumatic incidents. I look forward to our partnership.

Sincerely,

Jami Resch
Chief of Police

JR/tws

OIR Seventh Report – April 2020

Portland Police Bureau Responses

RECOMMENDATION 1: The Bureau should routinely refer officers for firearms training that includes stress recognition and reduction after any incident involving firearms use that indicates misperception of target or surroundings.

Agree, current practice. As noted in the OIR Group Report, remedial training was provided to address "stress recognition and reduction" prior to this recommendation. The Police Review Board receives the Training Division Review and a presentation of the facts surrounding the incident. The Police Review Board then makes recommendations related to training, policy and procedure. These recommendations can include referrals for training.

The Training Division recently conducted Active Threat Training during 2019 In-Service. This consisted of skills and scenario-based training using marking cartridges to simulate stress and show where officers' rounds impacted after shots were fired. The training included incidents where the target or backstop created hazards and students had to make decisions and adjustments accordingly.

In addition, the Training Division purchased a virtual reality training simulator (VIRTRA) which creates a nearly 360 degree scenario. Once the designated room has been properly outfitted, the Training Division will be able to more readily able to administer the type of training suggested.

RECOMMENDATION 2: The Bureau should meet with leadership from the District Attorney's Office and the Community Mental Health Director to explore compassionate solutions to the problem of arrested persons who will be released without charge but are determined to be in mental health crisis and in need of further evaluation and/or treatment.

Agree. The Bureau remains a willing partner to discussions between the District Attorney's office and the County Mental Health Director. The Bureau has been a strong advocate for resources for individuals who are being released from custody or treatment, including sustainable housing and follow up support to increase their likelihood of long-term recovery

RECOMMENDATION 3: During critical incident reviews, whenever a Bureau-initiated tactic or frequently-used technique does not produce the desired results (such as when a subject escapes from a containment perimeter), the Bureau should conduct an analysis with the objective of improving those tactics and techniques in future incidents.

Agree, current practice. Directives 1010.00 (Use of Force), 1010.10 (Deadly Force and In-Custody Death Reporting and Investigation Procedures) and Training Division SOP 7-1 (Officer Involved Shooting / Use of Force Training Division Review Process) require a Training Division Review following a deadly force incident or an After Action Review in which a supervisor notes a training issue. The

lieutenant assigned to conduct the review for a particular incident consults with the subject matter experts in the Division during their review. Lessons learned from the review are used to inform future training.

RECOMMENDATION 4: The Bureau's review process should examine an officer's use of profanity when confronting a subject, assess the totality of the circumstances, and determine whether the language used was consistent with the Bureau's expectations.

Agree: This practice is covered under Directive 310.00 Professional Conduct and Courtesy and specifically Section 2.2 which states "The use of profanity is generally prohibited, except when necessary to quote another person in reports or in testimony. All other use of profanity will be judged on the totality of the circumstances in which it was used. Members shall document uses of profanity in a police report." While the use of profanity in a deadly force incident is not a separate area of review, the language itself is evaluated given the totality of the circumstances in each deadly force incident.

RECOMMENDATION 5: The Bureau should ensure that Training Division Reviews consider whether officers articulated a plan, and whether any failure to do so was consistent with training under the circumstances.

Agree, current practice. The Training Division Review uses the Critical Decision Making Model as a foundation of its review. The Training Division assesses whether or not the officers formulated a plan, and whether or not their actions followed training doctrine. Training Division SOP 7-1, a. Pre-Application of Force Analysis states*:*

i. Circumstances surrounding the initial police response
ii. Planning process
iii. A determination of whether or not the actions of the officers on scene were reasonable and consistent with training.

RECOMMENDATION 6: In officer-involved shooting reviews, the Bureau should assess the risk calculation of involved officers, and when appropriate provide additional training on how best to assess that risk.

Agree, current practice. The Training Division Review includes an assessment of the threat and risks involved in an incident from initial contact with the subject. Furthermore, the Training Division evaluates the Officer's response and ability to develop a working strategy. Bureau policies require a risk analysis prior to engaging in a number of activities, for example foot pursuits, vehicle pursuits, contacting subjects suffering from mental health issues and contacting subjects armed or believed to be armed.

2019 and 2020 In-Service included risk analysis training in Patrol Procedures and Police Vehicle Operations.

RECOMMENDATION 7: Whenever evidence is moved at a crime scene, the investigation and analysis should consider whether there were alternative methods to accomplish post- incident objectives.

Agree. The Administrative Review of a critical incident includes a review of Post Shooting Procedures. Directive 640.10 – Crime Scene Procedures is included within this area of review. When evidence is moved at a crime scene, Internal Affairs will assess whether or not such action was within policy. Furthermore, the Training Division review will assess whether or not moving the evidence was consistent with training.

RECOMMENDATION 8: Whenever involved officers are also assigned a post-incident tactical role, the investigation and analysis should consider whether it was necessary to assign them such a role.

Agree, current practice. The Training Division Review includes several sections on supervision and how the post shooting response was managed by arriving supervisors. The separation of involved members and witnesses, crime scene management and use of resources are factors analyzed during the review. Per Training Division SOP 7-1, Section 4 - Training Analysis, d - Supervisory Analysis:

xi. Whether or not the supervisor's post incident actions were reasonable, consistent with training, and consistent with the principles of crime scene management

xii. A determination of whether or not the supervisor's actions were reasonable and consistent with training.

RECOMMENDATION 9: The Bureau and Police Review Board should ensure that officer-involved shooting reviews do not begin and end with a citation to the action-reaction principle but must critically assess other tactical options that might have driven a different result.

Agree, current practice. As stated by OIR, this recommendation was made in their 2019 Report. It is important to note, this incident occurred prior to the Police Bureau receiving the recommendation. The Police Bureau's previous response stated: "Although the action-reaction principle is a key tactical consideration it should not be the only principle critically assessed, and additional tactical options should be considered. The Training Division will continue to review these incidents with an eye toward an evaluation of cover, time and distance, as these tools can be used to minimize the advantage of action versus reaction."

RECOMMENDATION 10: Bureau officer-involved shooting protocols should be modified to require routine discussion and analysis regarding any decision by officers not to call or wait for backup before tactically engaging a subject.

Agree, current practice. Regarding this particular recommendation, it is important to note the case involved a two-person car. When working in a two-person car, officers are presumed to have adequate cover to make initial contact with a person.

The Training Division Review evaluates decisions using the Critical Decision-Making Model. Every member's tactics are analyzed with respect to their actions based upon assessing threats, risks involved and their obligations to take action given the particular circumstance. This includes a review of the member's decision on whether or not to call on additional resources, based on the totality of the circumstances.

RECOMMENDATION 11: The Bureau should develop protocols to ensure that the Bureau's Behavioral Health Unit's resources are not used for a purpose inconsistent with its mission.

Agree. Homicide Detectives investigating an Officer Involved Shooting (OIS) will not ask BHU officers to interview involved suspects regarding their actions during the OIS. Detective Division will memorialize this in its Officer Involved Shooting SOP within 30 days.

RECOMMENDATION 12: The Bureau should modify its protocols so that investigators are tasked with either collecting medical and toxicological evidence in cases where individuals are injured but not killed in police shooting, or documenting their inability to do so.

Agree, current practice. Detective Division will memorialize this practice within their OIS SOP within 30 days to ensure that it is not overlooked in any future investigations.

RECOMMENDATION 13: In cases where Bureau officers encounter subjects in a closed structure, investigators and reviewers – including Internal Affairs, Training, and the Commander – should explore and consider whether safer tactical alternatives existed to forcing the entrance open. This would include considerations of (1) whether the arrest team could take safer positions or employ mobile cover such as ballistic shields before opening the entrance; and (2) whether it would be practical and prudent to delay forcing the entrance until the arrival of SERT and crisis negotiators.

Agree, current practice. The Training Division Review provides a comprehensive look at all of the actions taken during an incident based upon the Critical Decision-Making Model. In fact, following the incident from which this recommendation stems, the Training Division provided classroom, skills and scenario-based training covering emergency entry (versus barricaded subjects) tactics and considerations during 2020 In-Service.

RECOMMENDATION 14: The Bureau should emphasize alternative ways to approach an armed or possibly armed subject, as well as options for improving cover and explore these issues as a component of the analyses performed by its subject expert internal reviewers, specifically the Commander's Review and the Training Division Review.
This component would be most effective if stated separately from the policy determination.

Agree, current practice. The Training Division Review SOP outlines a robust and comprehensive analysis of the incident subject to review. Subject matter experts review and evaluate the tactics used by officers and make recommendations for future training. Tactical considerations/decisions that may have

been more effective, as determined by the Training Division, should be included within the Training Review; and shared with the member after the conclusion of the Administrative Review.

RECOMMENDATION 15: When a K-9 is used in a shooting incident, evaluation of the K-9 deployment should be part of the Training Division Review, Commander's Review and Findings, and Police Review Board discussion.

Agree, current practice. The use of any Specialty Unit, tool or apprehension strategy is included in the Training Division Review. Per Training Division SOP 7-1, Section b. Application of Force Analysis:

> *iv. A summary of key decision points.*
> *v. Whether or not attempts at de-escalation were made.*
> *vi. Whether or not the member considered other options, including lower levels of force to resolve the situation.*
> *vii. Whether or not additional resources were necessary and if so, whether or not they were requested.*
> *viii. A determination of whether or not the involved member's actions were reasonable and consistent with training.*

In instances where a K-9 is used as cover, the use of the K-9 is included within the area of review titled "Operational Planning and Supervision." This area of review focuses on the key decisions made by members prior to the application of force, including recommended findings on whether or not the decisions made were consistent with Policy.

RECOMMENDATION 16: If an officer has watched video of an incident prior to being interviewed about that incident, Internal Affairs investigators should probe the extent to which that officer's perceptions may have been influenced by the video.

Agree. Internal Affairs will add this line of questioning to the Investigator Checklist for involved and witness members and reinforce this additional line of questioning through the weekly investigator's meetings.

RECOMMENDATION 17: The Bureau should initiate a dialogue with the Medical Examiner and District Attorney regarding the potential legal and accountability implications of a finding that a use of deadly force by police officers constitutes a suicide.

Disagree. The Police Bureau does not have the authority to, nor should it attempt to, influence the District Attorney's or Medical Examiner's decisions related to cause of death investigations.

In the case of the Medical Examiner, it is within the purview of their office to determine the manner of death. In order to maintain transparency in these investigations, the Police Bureau should not make any effort to influence the independence of the Medical Examiner's determination.

The District Attorney's Office has a practice of having all uses of deadly force reviewed by a Grand Jury, regardless of the Medical Examiner's determination. Again, the Police Bureau should not make any efforts to influence the independence of the District Attorney's Office decisions.

RECOMMENDATION 18: The Bureau should ensure that its review protocols evaluate the threat level presented to officers during the entire duration of the application of deadly force.

Agree, current practice. Both the Administrative and Training Review of an application of deadly force include an analysis of the risk presented and the member's response. The Training Review assesses the member's response using the Critical Decision-Making Model, and the member's responses are evaluated at key decision points throughout the incident.

RECOMMENDATION 19: The Bureau should accept the Police Review Board recommendation to develop written protocols, following an opportunity for public input, setting out the parameters for when video evidence of a critical incident is to be released to involved family members and the general public.

Agree. This recommendation was accepted by the Chief of Police and assigned to the Public Information Officer (PIO). The PIO developed an infographic for public release outlining the timeline for a use of deadly force investigation.

Throughout the investigation, the Police Bureau works with the District Attorney's Office and other investigative entities to ensure timely release of information in a manner that does not impact the effective completion of the underlying investigations.

RECOMMENDATION 20: The Bureau should develop a standard practice of meeting with family members and convening a community meeting within days of an officer- involved shooting or other critical incident to listen to concerns and explain the investigative processes.

Agree in part. Every use of deadly force has its own unique fact pattern and subsequent impact on the community. The Police Bureau strives to be as transparent as possible, while still preserving a thorough and un-biased investigation into the use of deadly force. Police Bureau representatives meet with the family and provide public information as soon as it is appropriate to do so. Given these factors, we have concerns regarding a policy that requires a meeting "within days" when it may not be appropriate to do so.

RECOMMENDATION 21: The Bureau should develop protocols to ensure that where a critical incident is captured on video, investigators obtain pure statements from involved officers regarding their observations and actions, and then provide officers an opportunity to review the video of the event followed by subsequent relevant questioning.

Agree. The Police Bureau is in the process of developing a Body-Worn Camera policy which addresses this issue. The Police Bureau is currently negotiating the policy with the Portland Police

Association. We recognize OIR's recommendation for when members are allowed to view video footage of a critical incident as the national best practice

RECOMMENDATION 22: Bureau executives and City representatives should meet with Portland State University leadership with the aim of agreeing upon written procedures that would ensure the cooperation of field personnel with all investigations conducted by Bureau Detectives and Internal Affairs investigators.

Agree in principle: Professional Standards Division will work with the City Attorney's Office and PSU leadership in an attempt to agree on such written procedures. However, as PSU is a separate organization with its own interests in how to participate in such investigations, it may not be possible to reach an agreement on all aspects of cooperation

RECOMMENDATION 23: Bureau executives and City representatives should convene a meeting with Portland Fire Bureau and American Medical Response leadership to develop written protocols to ensure that City departments and contractors cooperate with the Bureau's criminal and internal investigations.

Agree with the recommendation as to Portland Fire and Rescue, and **agree in principle** as to American Medical Response (AMR). AMR is a separate organization, under contact with Multnomah County. AMR has its own interests in how to participate in such investigations, and it may not be possible to reach an agreement on all aspects of cooperation. However, Professional Standards Division will work with the City Attorney's Office and PF&R in an attempt to agree on such written procedures.

RECOMMENDATION 24: The City should ensure there is an effective enforcement mechanism for defiance or non- compliance with IPR's subpoena authority.

Agree in principle. IPR is an independent agency falling under the Auditor's Office. The Police Bureau would support any efforts made by IPR to enforce non-compliance with their subpoenas, but the Police Bureau does not have the authority to ensure enforcement.

RECOMMENDATION 25: The Bureau should direct its Training Division staff and other members to refrain from opining about the appropriateness of the use of deadly force in any forum, including grand jury proceedings, until that administrative determination has been made by the Bureau.

Agree, current practice. As part of our Administrative Investigation, the Training Review identifies decision points in the deadly force incident, provides information on the training provided relative to the decision point but has ceased the practice of making a determination if the involved member's actions comport with policy or not. The Training Division made this change in practice prior to this recommendation. Training Division instructors were instructed their role is to provide information on training and not to make a determination if an action is in or out of policy.

As it relates to our members being called as witnesses in a criminal proceeding, the Police Bureau does not have the authority to direct the line of questioning by the District Attorney's Office.

RECOMMENDATION 26: The Bureau should make clear its expectations for the Responsibility Unit Manager's assessment of a critical incident, and when the Review and Findings memorandum does not meet those expectations, the Commander should be instructed to make necessary revisions.

Agree. The structure of our Administrative Reviews changed in 2018. A key change in our process was the inclusion of recommended findings from the Internal Affairs (IA) Investigator. The IA Investigator's finding(s) and supporting rationale are now provided to the RU Manager for purpose of making proposed findings. In cases where the RU Manager concurs with the IA Investigator's recommended finding and rationale, the RU Manager can adopt the recommended finding as the proposed findings. In cases where the RU Manager does not concur with the recommended findings or underlying rationale, the RU Manager is expected to provide their proposed findings and underlying rationale. The RU Manager's proposed findings are then reviewed by the Chief's Office, Internal Affairs, and Independent Police Review. Any of these bodies can return the RU Manager's findings for additional work.

RECOMMENDATION 27: The Bureau should change its officer-involved shooting protocols to require all officers who use deadly force are interviewed before the end of their shifts.

Disagree. All witness members are currently interviewed prior to the end of their shift unless there is a life or safety consideration that would prohibit it. When necessary, involved members are compelled to provide an on-scene public safety statement in order to further investigative efforts. Under our current process, involved members are asked to provide a voluntary statement to investigators. When members do not provide a voluntary statement, they are subject to a compelled and comprehensive interview within 48 hours of the incident, absent extraordinary circumstances. We believe the delay is necessary to fully process the scene, review witness statements, and uncover evidence that will allow us to conduct a comprehensive interview of the member.

RECOMMENDATION 28: When the investigation and review of an officer-involved shooting extends beyond the 180-day deadline established in the Bureau's agreement with the U.S. Department of Justice, the Bureau should identify the cause of the delay, evaluate potential remedial measures, and fully document these efforts.

Agree, current practice. Paragraph 123 of the Department of Justice Agreement with the City of Portland reads "If PPB is unable to meet these timeframe targets, it shall undertake and provide to DOJ a written review of the IA process, to identify the source of the delays and implement an action plan for reducing them." In practice, IA assesses all overdue timelines on a quarterly basis, produces a detailed report using our Administrative Case Reporting System (ACRS) and presents said report to the Chief of Police and DOJ for review.