Report to City of Portland

PORTLAND POLICE BUREAU OFFICER-INVOLVED SHOOTINGS

Fifth Report / February 2018

OIR GROUP
Michael Gennaco
Robert Miller
Julie Ruhlin

OIR GROUP

323-821-0586
7142 Trask Avenue | Playa del Rey, CA 90293
OIRGroup.com

Table of Contents

Foreword

OIR Group has been reviewing Portland Police Bureau critical incidents since 2010. Counting the six incidents we review in this report, we have examined 41 officer-involved shootings and in-custody deaths, occurring as early as March 2004 and as recently as June 2015. In that span of time, we have seen continued evolution in the way the Bureau investigates and reviews critical incidents. As we note in our specific case narratives, we continue to find criminal and administrative investigations that are thorough and fair. While we note gaps when we find them, the Bureau's review mechanisms identify and document significant performance issues, in the Training Division Reviews and, somewhat less routinely, in the Commander's Memoranda. The issue spotting and analysis indicates an ability to be self-critical about deadly force incidents and turn sometimes tragic outcomes into opportunities for learning and organizational growth.

Particularly remarkable in this set of six incidents is that in four of them, individuals produced weapons that either were or closely resembled actual firearms and that in two of them officers were shot by those weapons prior to the use of deadly force. However, to the Bureau's credit, even in the deadly force incidents where officers were struck by gunfire, the Bureau considered its employees' decision making with a critical eye and found some of those decisions less than optimal.

Throughout our seven years of experience in Portland, we have by and large been complimentary of the Bureau's complete and objective investigations – an assessment that continues through this report – along with its willingness to engage with us when we have identified issues of concern. Administrative investigators have ably expanded the scope of their investigations to include greater focus on the tactical decision making that precedes a critical incident and can greatly influence its outcome. Moreover, and in part to address issues we have raised in past reports, the administrative investigators have expanded their fact-gathering mission to include interviews of paramedics in order to provide a more complete record on the Bureau's post-incident response.

But the Bureau's accountability mechanisms have not always kept up with these demands all the way through to the end of the review process. We see too often the Police Review Board apparently declining to scrutinize sub-standard tactical performance identified earlier in the administrative review process or documenting any such deliberation.

Community expectations for law enforcement officer performance have perhaps never been greater, with media outlets reporting on controversial critical incidents throughout the country on a regular basis. As professionals who have worked in the police oversight arena for well over a decade, it is telling to see terms like "tactical decision making" and "de-escalation" become part of the popular lexicon, with community members focusing on issues surrounding police shootings and asking critical questions to an unprecedented degree.

We understand that this is a demanding and sometimes frustrating time for law enforcement officers and executives, with public scrutiny extending to them in ways that can be uncomfortable and unsettling. Yet in this period of discomfort there is an opportunity for increasing public awareness and engagement. Portland's Police Review Board could be well-positioned to aid in this effort, and we urge the Board to capitalize on its unique composition of community members, oversight professionals, and police officers and actively engage in the discussion regarding the root causes of the incidents it reviews. To that end, a cornerstone recommendation of this report is to facilitate a more focused inquiry by the Police Review Board of pre-shooting tactical decision making, including the development of disciplinary recommendations or remedial action plans targeting sub-optimal performance.

Unlike prior reports, where the cases we reviewed were organized around a unifying theme or similar fact pattern, the incidents we discuss in this report

involve a variety of factual scenarios. One incident involved a vehicle pursuit of burglary suspects followed by a brief foot pursuit that ended in non-fatal gunshot wounds to both the suspect and pursuing officer, and the death of a police K9. Another shooting followed two officers' attempt to detain three individuals in a retail parking lot who had raised their suspicions. One involved the response to a threat posed by a man walking on the freeway pointing a gun at passing vehicles, while another involved a vehicle maneuver at a gas station to stop and apprehend a gang member with active warrants and a history of fleeing from officers. Another shooting was actually a gunfight between an officer and an individual who was behaving suspiciously around children. And another involved an apparently suicidal man who ran out of a house at officers who were just beginning to make a plan to detain him.

Nonetheless, there are several common themes. Some of those themes are familiar to readers of our prior reports – concerns about the length of time between an officer-involved shooting and the Bureau's first opportunity to get an account of the incident from the shooting officers; observations about sergeants who assume tactical roles rather than maintaining supervisory control at the scene of a critical incident; and concerns about the length of time it takes to render medical aid to individuals injured in a shooting. Other common themes are a product of changing times and the Bureau's own development – concerns about the scope of the Police Review Board's review practices, and cautions about how the Bureau should regulate officers' access to the ever-growing amount of video evidence of critical incidents.

Another consistency over our years of reviewing critical incidents in Portland is the level of cooperation we have received 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 generous with their time and helpful in answering our questions and engaging 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 with each others' opinions, we appreciate and value the willingness to engage in a respectful way and the Bureau's openness to outside perspectives. We look forward to this continuing dialogue as the Bureau welcomes its newest Chief.

Scope of Review

As we have done for each of our prior reports, we reviewed all of the Bureau's investigative materials for each of the six critical incidents we evaluate here, including the Detectives' and Internal Affairs' investigations, as well as grand jury transcripts where available.[1] 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 interviewed 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.

The investigative process in Portland that we review for each officer-involved shooting includes a series of steps involving different participants. On the date of the incident, investigators from the Bureau's Detectives' Division assume the primary responsibility for investigating the incident, heading up the criminal inquiry, sometimes supplemented by investigators from the East County Major Crimes Team. The work of the Detectives is routed to the District Attorney's Office, which presents the incident to a grand jury, which makes the determination of whether the officers should face criminal charges resulting from their actions. Parallel to that investigation, the Internal Affairs Division conducts an administrative investigation to examine whether any of the involved officers or supervisors violated Bureau policies before, during, or after the shooting. The Training Division performs its own analysis of the events to assess whether officers performed consistently with how they were trained, and whether the incident points to any deficiencies in training that need to be addressed. Both the Detectives' and Internal Affairs' investigations as well as the Training Division Review[2] are routed to the involved officers' Commander, who evaluates all of the

[1] The District Attorney releases grand jury transcripts in fatal officer-involved shootings but does not release them if the shooting is not fatal.

[2] For the cases we address in this Report, both the Commander and members of the Police Review Board had access to the Training Division Review to make their assessments. As we discuss in greater detail below, however, recent changes to the Bureau's policy (10.10.10) will result in the Training analysis being completed after the Commander's review and the Police Review Board meeting, depriving those reviewers of the trainers' insights into whether officers' performance was consistent with Department training standards.

information and makes a recommendation about whether the involved officers' actions violated Bureau policy. All of this information and analysis is sent to the Police Review Board, which makes recommended findings and disciplinary results that are forwarded to the Chief (and in those cases where a sustained finding will result in formal discipline, to the Police Commissioner) for determinations as to final outcome.

Our analysis centers on the quality and thoroughness of the Bureau's internal investigation and review of each of the incidents presented. We look at relevant training and policy issues, and corrective actions initiated by the Bureau. We do not opine on whether any particular shooting, or related tactic or use of force, is within policy, but do point out where we see officer performance that appears to be inconsistent with Bureau expectations. We also identify issues that were not 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.

In one case, we comment about testimony presented by the District Attorney's Office to the Grand Jury that considered the legality of the officer's decision to use deadly force. To that Office's credit, it publicly releases grand jury transcripts on fatal shootings so that all can review and consider the presentation. While we recognize the focus of our review primarily relates to the Police Bureau, in the full interests of transparency, and because the grand jury proceedings are inextricably linked to the Bureau's investigation and review, we offer our perspective so that the Bureau can continue to dialogue with its criminal justice partner to support the Bureau's commitment to best practices and retaining the public's trust in the process.

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

SECTION ONE

Officer-Involved Shootings

Summary and Analysis

March 12, 2014 ◦ Kelly Swoboda

On the date of the incident, several Police Bureau officers responded to a 911 call to look for a subject driving a van who was reportedly watching teenaged girls as they walked home from school. One officer located a vehicle matching the description of the van and had a brief conversation with the driver. The officer at first believed that the person was not the subject they were looking for because he was not bald headed as described. However, as he drove past the van, the officer noticed that the plate on the back of the van was different than the front plate, which corresponded with information that had been initially broadcast about the subject vehicle.

The officer broadcast his observation and said that he thought the subject had walked to the nearby library.[3] Officer John Romero and another officer were close by and responded to the library. Officer Romero then returned to the initial area and noticed a parked van. He saw a male subject who he believed may have come from the van so he walked after him in an attempt to talk to him. The

[3] The first officer was the subject of an Internal Affairs investigation related to his performance in this matter.

subject, later identified as Kelly Swoboda, initially ignored Officer Romero's instruction and continued to walk away.

Officer Romero caught up with Swoboda and ordered him to sit down, pointing to a nearby retaining wall. The subject briefly complied then pulled a gun from his pocket and began to shoot at Officer Romero. Officer Romero sustained one gunshot wound to his right hand and forearm as he returned fire, fatally wounding the subject. It was eventually determined that Officer Romero fired four rounds during the incident.[4]

Responding officers arrived at the scene and provided medical attention to Officer Romero. Because Mr. Swoboda's gun had not been secured and was observed close to where he had fallen, the officers did not immediately approach. After a sergeant arrived, the on-scene officers deployed a ballistic shield and coordinated an approach. Officers handcuffed Swoboda and then moved back without rendering aid or checking him for a pulse or any sign of life. Moreover, only two paramedics were allowed to approach Swoboda, and apparently for the sole purpose of confirming and declaring him deceased.

Timeline of Investigation and Review

3/12/2014	Date of Incident
5/2/2014	Internal Affairs Investigation completed
5/20/2014	Training Division Review completed
5/20/2014	Detectives' Investigation completed
7/29/2014	Commander's Findings completed
9/24/2014	Police Review Board convened

[4] There was a discrepancy between a fully loaded firearm and the number of casings retrieved, leaving some question about the number of rounds Officer Romero fired.

Investigation and Review

Timeliness of Investigation

Under the current settlement agreement with the U.S. Department of Justice, the Police Bureau is mandated to complete all administrative investigations and review within 180 days. This investigation and review was conducted in 208 days. The Bureau carefully charted out a time line to determine the cause for the delay and found that a delay in receiving the completed criminal investigation was largely responsible, in that the case book was received by Internal Affairs 69 days overdue. No explanation was provided by Detectives as a reason for the delay. As a corrective action, the Bureau recommended that the Internal Affairs Captain would in the future ask for a written explanation for any delay in receiving the criminal investigation.

Training Questions Provided to Investigators

The investigative report includes a document containing questions posed by the Police Bureau's Training Division relating to tactical and training issues. Using the expertise of the Bureau's training personnel to identify issues and develop questions to be asked of involved officers is a good investigative practice and a testament to the development of an effective system designed to ensure thorough and insightful interviews. Having Training provide guidance to investigators prior to interviews is an effective way to assist in compliance with the Bureau's investigative deadlines, both by helping to avoid the situation where a case is returned to Internal Affairs for additional interviews or questions and by helping Training get an early sense of potential concerns to assist with the timely preparation of its written analysis. While there are not always questions reduced to writing and included in the case file, Training and Internal Affairs have established a common practice of exchanging ideas at a regularly scheduled case status meeting. The Bureau should consider the advantages of regularly documenting this part of its investigative process.

Delay in Interviewing Involved Officer

The involved officer was interviewed by detectives two days after the incident. As we have consistently stated in the contexts of these reports, this delay in interviewing the officer runs contrary to investigative practices and in this case left the Bureau without any information about the shooting incident from the one most knowledgeable about the incident for at least two days. To the credit of the City, as a result of a new collective bargaining agreement, the City is rid of the

"48-hour rule;" Internal Affairs officers can and should now interview involved officers about their actions and state of mind the date of the incident.

Most recently, the District Attorney raised concerns about the implications of the new rule on criminal investigations and suggested that officers not be interviewed by Internal Affairs until the grand jury had made a determination. After duly considering those concerns, and hearing the competing interests advanced by IPR, the Portland City Council enacted a rule requiring immediate interviews of involved officers. We look forward to the time in which we review officer-involved shootings where this best investigative practice has been implemented.

Grand Jury Testimony of Clackamas County Detective

During the grand jury presentation, Multnomah County prosecutors called a Detective from an adjoining County to testify about matters that were not part of the Detectives' criminal investigative report. The Detective testified that, prior to Swoboda's demise, she had been investigating him for the kidnaping of a 23-year-old woman. She testified that the victim had been found in the middle of a road with major head injuries with duct tape on her ankles. According to the victim, she was at her place of business when a man entered and accosted her at gunpoint, hit her in the back of the head and dragged her to a van. The victim said that the male duct taped her wrist and ankles together and drove away. According to the victim, she jumped out of the van while it was moving to get away. The Detective testified that in short order, investigators were able to develop evidence indicating that the perpetrator was Swoboda, who was also being sought for possible multiple bank robberies, had a warrant for driving under the influence, and a parole warrant from the US Marshal's Office.

The Detective was also asked about the processing of Swoboda's van after the shooting incident. She was shown photographs of the inside of the van that she identified as blood smears, believed that they might have come from the victim, but had not received final results from the lab. The Detective testified about the existence of tire chains in the van, which she speculated might have been devised as a way to secure people because it had been secured to the seat rail with a padlock. The Detective testified about a pillow and sleeping bag behind the driver's area and speculated that Swoboda had been sleeping in the van. She testified that food items, a shower kit, and a bicycle had been found in the van.

The prosecutor showed the Detective photographs of pornographic movies with a follow up question about the titles:

Q: Some of them at least seem to indicate an interest in teenaged girls, is that right?

A: Yes. Yes.

Q: For example, “Tight Teen Sluts” is the title of the black one the left-hand side.

A: [No answer]

The Detective testified that garbage bags and white latex gloves were found in the van as well as additional porn magazines with at least one focusing on young girls. The prosecutor followed up:

Q: There appears to be an interest again in teenaged girls, in particular, because of the titles, “18”, I guess and “Just 18” are some of the titles.

A: Yes.

The prosecutor then directed the Detective’s attention to the discovery of zip ties located in the van.

Q: Okay. So could these be used potentially to restrain someone at the wrists?

A: Yes.

At this point, the more senior prosecutor took over the questioning of the Detective:

Q: In summary, we’ve just seen the photos of the items in the back of Kelly Swoboda’s van that you examined after the shooting.

A: Yes.

Q: As an investigator, looking at chains mounted to the floor, ropes, zip ties, teen pornography, padlock, what are you thinking when you see all this?

A: I’m thinking exactly that one victim got away, and he wasn’t going to let the next one get away. This is what it looks – that was our impression. Our discussions at my office is that he was coming up with a better way to restrain somebody in his vehicle.

Q: And did it look to you that Kelly Swoboda had essentially converted this minivan into a moveable dungeon or torture chamber where he could hold someone captive and carry them away?

A: Yes.

The prosecution team then directed the Detective to a 1999 Driving Under the Influence arrest of Swoboda that was originally called in as a suspicious person trying to get a 13-year-old girl in his vehicle. The Detective noted that the vehicle had switched plates, and that they found a sawed off shotgun, latex gloves, duct tape, and a razor blade knife in the car.

Returning to the van inventory, the Detective indicated that sexual lubricant was also found. She was then asked about duct tape:

Q: And I don't know that you already mentioned this, that duct tape was located.

A: No. There was no duct tape located.

Q: No duct tape?

A: No.

Finally, the Detective testified that a gun case matching the gun found next to Swoboda after the shooting was found in the van, ammunition of a caliber matching the gun, and an "old beat-up saw."

In American trials, the rules of evidence require judges to consider the admissibility of testimony presented to the finder of fact. Judges are often required to determine whether the probative value of the evidence is outweighed by the prejudice the evidence may cause. The reason for this rule is that basic principles of American jurisprudence teach that juries should decide guilt or innocence based on direct evidence as to whether a crime has been committed, not because of distaste or enmity for the individual. The goal is to prevent juries from being inflamed by passion as a result of being exposed to prejudicial evidence. Evidentiary rules also exist to prohibit introduction of evidence concerning prior convictions that are distant in time, to preclude witnesses from speculating, and to prevent counsel from asking leading questions. In a grand jury proceeding, where no judge or defense attorney is present, the rules of evidence still apply, largely unchanged. Oregon law limits evidence admissible to the grand jury to the same evidence that would be admissible in a criminal trial.

In the infrequent event that an officer is tried in connection with an officer-involved shooting, attorneys for the charged police officer often attempt to base the defense at least in part on evidence that makes the person who was shot look bad in the eyes of the jury, such as gang membership, prior criminal record or status, evidence that the person had a history of illicit drug use, or other bad acts. The theory often advanced is that the evidence is relevant to establish that the person shot was dangerous and presented a real threat to the police officer when deadly force was used. Such evidence is more likely to be admitted if the officer had knowledge of the prior criminality or bad acts since that knowledge may have contributed to the officer's level of fear in attempting to apprehend the individual. Another but less successful theory often advanced for admission of such evidence is that a suspect who is a fugitive from justice, has a history of being under the influence, or has a lengthy criminal record and is more likely to act aggressively toward any attempt at apprehension because of the strong desire not to go to prison.

The difficulty with admitting such evidence is that a jury may be so prejudiced by the distasteful information that they may find in favor of the police officer because the suspect was a "bad guy" who may have "needed killing." The rules of evidence are designed to protect against such consequence so that juries focus on the evidence that directly establishes the elements of the crime, not evidence that "dirties up" the decedent.

This balance that judges must strike has played out publicly in real officer-involved shooting cases. For example, in the manslaughter trial in California involving the shooting death of Oscar Grant, evidence about the fact that Grant was on parole, probation, and had a conviction for possession of an illegal firearm was excluded. In the recent criminal trial involving the shooting death of Philando Castile, the judge excluded evidence of Castile's past marijuana use but allowed evidence about marijuana allegedly used by him the day of the shooting. And in pre-trial motions in the prosecution involving the shooting death of Walter Scott, prosecutors filed a motion asking a judge not to allow details about Scott's criminal history, unpaid child support, drug use or other "misconduct" to be admitted as evidence in the trial, characterizing it all as "prejudicial" information that could unfairly influence the jury.[5] Finally, in a civil trial in Oregon involving allegations that an Oregon State Police Officer used excessive force against a

[5] The defendant police officer in that case pleaded guilty before the judge ruled on the motion.

motorcyclist, the judge excluded evidence that the motorcyclist had expired registration and no insurance when he was pulled over, that he had multiple drunken-driving convictions and a past alcohol-related crash on his motorcycle.[6]

In the grand jury context, there is no judge to evaluate the probative value versus prejudice of evidence elicited by the prosecutor. There is no judge to determine whether the witness is providing factual evidence or being asked to speculate. There is no judge to determine whether leading questions are being used by the prosecutor in the grand jury. Under the current system, prosecutors themselves serve as the only check with respect to what evidence is presented to the grand jury.

In this case, Officer Romero had no knowledge at the time of the shooting of Swoboda's past criminal history or the items later discovered in the van. After our review of the grand jury transcripts,[7] we questioned the prosecutor's office about the presentation of the evidence cited above. One of the prosecutors who conducted the grand jury proceedings affirmed their belief that the testimony of the Detective was necessary, helpful and appropriate. The prosecutor further indicated that as a long time prosecutor in Multnomah County he was convinced such evidence would likely be admitted in a murder trial had Officer Romero been so charged. The prosecutor maintained that the fact that Swoboda had recently committed a serious crime, was in possession of evidence of that crime and was logically fearful of detection and apprehension by the police was all highly relevant in explaining his actions towards Officer Romero. The prosecutor indicated his belief that a contextual understanding of the events surrounding the case was critical for public understanding and trust.

Based on our collective experience as prosecutors and trial attorneys, including experience prosecuting police officers for using excessive force, we respectfully disagree. The probative value for introduction of evidence that Swoboda may have committed a serious crime and may have been fearful of apprehension by the police so that he used deadly force on Officer Romero is slight. Even if a prosecutor felt the need to introduce that evidence, it could have been presented to the grand jury in more concise fashion, through testimony that Swoboda was

---

[6] In some cases, judges limit the introduction of such evidence, for example, allowing admission of a past criminal conviction but disallowing the advocate from getting into the details of the crime.

[7] To the credit of the District Attorney, grand jury transcripts of fatal officer-involved shootings are usually released after the conclusion of the proceedings.

being sought for a kidnaping of a female and that preliminary blood evidence had been located in the van. Where the evidence introduced in the grand jury became extremely prejudicial and added no real additional probative value is when the prosecutors elicited details about the gruesome facts of the prior crime, the specific titles and photographs of the pornographic materials located in the van, and additional discoveries such as the presence of sexual lubricant. Moreover, the theory advanced by prosecutors above for admissibility does not apply to a 16 year old arrest for Driving Under the Influence. Finally, the leading questions by prosecutors eliciting agreement from the Detective that Swoboda had transformed his van into a "moveable dungeon or torture chamber" was speculative and of the highest level of prejudice.

Swoboda was clearly a man with a history of recent violence who shot Officer Romero. The uncontradicted evidence, supported by civilian witnesses, is that Officer Romero returned fire to stop the deadly threat presented. The grand jury presentation should have focused on the overwhelming evidence that Officer Romero acted in self-defense when he used deadly force. Unfortunately, the grand jury proceeding was infected with evidence about Swoboda's history, character, and presumed intent that was prejudicial, speculative, extraneous, and of extremely slight probative value especially when compared to the hard evidence that existed that the shooting was justified. Contrary to the opinion of the County prosecutors, in our view, the prejudicial evidence that was introduced did nothing to advance the public's "understanding and trust" in the grand jury proceedings.

Analysis and Issues Presented

Tactical Performance of Initial Responding Officer

As noted above, another Portland officer first encountered Swoboda when he was still in his van. During their encounter, the officer stayed seated in his patrol car. He did not ask the occupant for identification. Because he remained in his car, the officer was not able to check to see if the van had mismatched plates as had been broadcast. At the end of his conversation, he told Swoboda that police were looking for a van similar to his. It was only at the end of his encounter as he drove away that the officer recognized that the van had mismatched plates, too late to effectuate a timely detention.

To their credit, both the Training Division Review and the Commander's Memorandum identified the potential performance deficiencies of the officer and

the Police Bureau initiated a formal internal investigation into his actions. After a thorough investigation, the Bureau found that the officer's performance had violated policy, based on his decision to remain in his car during his encounter and his failure to identify Swoboda.

The identification of performance issues of a Bureau officer not even involved in the shooting itself is a testament to the Police Bureau's interest in a more holistic review of wider aspects of the incident for purposes of accountability, learning, and remediation.

Notification to Involved Officers of Internal Investigative Outcomes

Under current Police Bureau protocols, when an internal investigation is completed, Internal Affairs notifies the subject officer of the outcome via email. The Bureau should reconsider its use of this impersonal method. In order for internal accountability to be effective and remedial, the organization must embrace it and effectively dialogue with each employee about the reasons for the determination. In non-termination cases, the meeting should provide an opportunity for helpful discourse and to shape a productive path forward. Instead of email notification, the Bureau should require a supervisor within the officer's chain of command to personally communicate the results of any sustained internal investigation.

> RECOMMENDATION 1: the Police Bureau should modify its notification protocols so that a supervisor within the subject officer's chain of command is assigned to meet with the employee and communicate the disposition of any sustained internal investigation.

Tactical Performance of Involved Officer

The Training analysis found that Officer Romero displayed sound tactics overall in how he responded to the van, his subsequent encounter with Swoboda, and his use of deadly force. We agree. Training found however, that Officer Romero's decision to approach the van without updating dispatch was "generally acceptable but created identifiable risks." The Training analysis noted that while Officer Romero told other officers where he was going, responding officers were not aware of his new location or activities. Despite this issue being identified by Training, the Police Review Board inexplicably found that Officer Romero "communicated throughout the incident to other enforcement officers."

The "identifiable risk" materialized into real consequences in this incident, as responding officers initially went to the wrong location in response to Officer Romero's broadcast of shots fired. Officer Romero himself admitted having trouble initially advising officers of his location after he had been shot and returned fire, initially forgetting the street name under the stress of the situation. This consequence emphasizes the importance of officers keeping dispatch updated on location before becoming involved in a tactical situation.

This ramification was exacerbated by the fact that Officer Romero did not request backup or radio officers of his location after Swoboda first ignored his instructions. While the encounter with Swoboda was brief, if Officer Romero had broadcast his location or requested assistance, the officers positioned close by could have responded more readily and the presence of additional arriving officers may have altered Swoboda's decision to fire on the lone officer. The Training analysis did not discuss this additional decision point in the scenario.

On a broader note, while the Bureau has a mature and sophisticated officer-involved shooting review process, there are still gaps in how it communicates issues identified during the after action review to involved officers. For example, while the Training analysis spent significant time identifying the tactical decision-making of Officer Romero (optimal and less than so), no formal mechanism currently exists to ensure that this insight is eventually discussed with the involved officer. At the conclusion of the review process, the tactical decision points identified by the Training Division and/or Commander should be discussed with the officer as an opportunity for learning and tactical development.

While the Bureau may conduct a tactical debrief of involved officers apart from the officer-involved shooting process, the issues specifically identified in the Training analysis or Commander's Memorandum may not be covered, especially if the debrief occurs before the subsequent documents are prepared. Moreover, the file should capture documentation that the issues identified by Training or the Commander were specifically discussed with the involved officers.

> RECOMMENDATION 2: The Police Bureau should develop a mechanism whereby a tactical debrief is scheduled with all officers involved in deadly force incidents, including any insights documented in the Training Division Review and the Commander's Memorandum. The occurrence of the briefing should be documented and included in the officer-involved shooting investigative file.

Involved Officer's Articulated Justification for Using Deadly Force

During his interview, Officer Romero said that as a result of him being shot by Swoboda, he feared for his life and used deadly force in return. However, Officer Romero went on to say that he also used feared that Swoboda would go into a nearby high school and drugstore. Clearly, the use of deadly force by Swoboda presented more than sufficient justification for Officer Romero to return fire. However, the speculative chance that an armed suspect may be a public safety danger to unidentified others, without more, would not constitute sufficient cause to use deadly force. In an urban environment such as Portland, virtually every police/civilian encounter will have a nearby school or commercial entity where people might be endangered by the subject's actions. When teaching the principles of deadly force, the Bureau instructors should focus on the particular, immediate threat to on-scene individuals and not on speculative "what ifs."

> RECOMMENDATION 3: The Police Bureau should advise its use of deadly force instructors to instruct officers that the basis for using deadly force should focus on the imminent danger presented by the subject's actions to them or identifiable third parties rather than speculative unidentified victims who may be in the vicinity.

De-Escalation Principles and the Use of Profanity

When Officer Romero encountered Swoboda, he issued commands but Swoboda continued walking away. According to Romero, Swoboda eventually stopped, he told Swoboda to "sit your ass down right there" and Swoboda briefly complied. Romero said he then ordered Swoboda to "get your fucking hands out of your pocket" at which time Swoboda produced a gun and began firing at him.

Police Bureau policy generally prohibits the use of profanity, unless it is used to establish control and potentially avoid the use of force. Recognizing the exception, some police professionals argue that such strong language can be useful as a display of "command presence" to show recalcitrant suspects that the officer means business. Other arguments can be made that profanity is inconsistent with principles of de-escalation, which call on officers to try to talk with subjects with the goal of calming them and defusing tense situations.

It is impossible to know whether the initial use of profanity assisted Officer Romero in gaining compliance, albeit briefly, or whether it set Swoboda off and contributed to his decision to shoot the officer. It would have been helpful to hear

from the Bureau experts on this issue, but it was not addressed by the Training analysis. In fact, when Training recounted the instructions given by Officer Romero, it omitted the profane language. As more and more police activity finds its way into the public arena, police instructions laced with profanity will be subject to additional scrutiny. It is incumbent on the Bureau's tactical experts to identify the use of profanity and consider its helpfulness or detriment.

> RECOMMENDATION 4: When an officer uses profanity in engaging a subject, the Training Division Review should identify it and opine upon its appropriateness.

Commendable Actions by Responding Officer

The investigative report revealed that when one of the initial responding officers arrived on scene, he replaced Officer Romero in holding the downed suspect at gun point and effectively directed responding traffic on how best to enter the scene. The responding officer's actions were commendable in taking control of the scene, and making initial quick and sound decisions.

Approach to Injured Suspect

In our past reports, we have referenced incidents in which arriving officers did not approach persons downed by gunfire because they were believed to be still armed. In those cases, the Special Emergency Response Team (SERT) was called to respond, and the individuals were not approached for long periods of time. Since then, the Bureau has deployed ballistic shields so that officers can more quickly approach injured but potentially still dangerous persons. In this case, the first field supervisor to arrive coordinated an approach using a ballistic shield. According to the reports, Swoboda was handcuffed and the officers then retreated. After paramedics arrived, the Bureau directed that only two of them could enter the scene to minimize the disturbance of evidence. Instead of a rescue mission, it appears that paramedics' role was to confirm that Mr. Swoboda was deceased. There is no written documentation that any officer checked Mr. Swoboda's vital signs or rendered emergency aid prior to paramedics' access to the scene. However, both the Training analysis and the Commander's Memorandum spoke only approvingly of the post-incident actions.

While the decision to deploy the ballistic shield so that officers could safely and quickly approach the downed suspect was laudable, questions still remain about whether officers could have more readily provided emergency aid. When the field sergeant arrived, he observed what appeared to be an unconscious subject

with a gun nearby. While certainly Swoboda had already used deadly force and remained a significant threat even though he appeared to be unconscious, after he was handcuffed, the potential threat significantly dissipated. At that point, as we have seen in other incidents, officers could have checked for signs of life and rendered emergency first aid. If the presence of the gun nearby still concerned responding officers, they could have secured it and removed it from the location. If paramedics were on scene, their rescue response could have been closely coordinated with the responding officers so that the full response team could have tended to Swoboda as soon as he was handcuffed and secured.[8]

As it was, Bureau officers backed away from Swoboda and then instructed paramedics that only two would be allowed to check on him because of a concern about disturbing evidence. That instruction suggested that in the view of the Bureau, the role of paramedics was not to rescue but just to confirm that Swoboda had expired.[9] While concern about preserving evidence is legitimate, it should not outweigh the interest in preserving life.[10] Ultimately, paramedics should retain the discretion to approach the suspect with whatever personnel they need to try to rescue the individual.

> RECOMMENDATION 5: The Bureau should continue to train its field sergeants on the need to render or coordinate first aid as soon as possible and should not instruct paramedics to downsize their response team in the interest of not disturbing evidence.

Use of the Tourniquet

One of the responding officers to the shooting recognized that Officer Romero was shot and bleeding and applied a tourniquet to his arm. The Training analysis found that the use of the tourniquet demonstrated "sound and effective tactics" and recommended expansion of tourniquet training. Yet the conclusion by the Training analysis is belied by evidence collected during the investigation. During his interview, Officer Romero complained about the application of the tourniquet,

---

[8] It should be noted that, to the credit of the responding officers and field sergeant, paramedics were timely called and staged nearby; the time between the use of deadly force and the deployment of the shield was approximately nine minutes.

[9] It was apparent that responding officers had concluded from their close observations while handcuffing Swoboda that he was deceased; however, that determination is best left to medical professionals.

[10] Of concern is the fact the Police Review Board credited this decision, finding that the responding sergeants "made and implemented plans not to disturb evidence."

stating his belief that the tourniquet was doing more damage than the gunshot wound due to it cutting off his circulation.

Once the paramedics arrived and took over care, they immediately removed the tourniquet and transported Officer Romero to the hospital for further treatment. When the Captain of the responding paramedic crew was asked during his interview if officers could have improved their response, he questioned the need for the application of a tourniquet under the circumstances and explained the potential drawbacks of doing so.

Based on the evidence collected during the investigation, it appears that the well-intentioned impulse of a responding officer to render first aid to a fellow officer may not have been either sound or effective under the circumstances presented. The Training analysis should have at least discussed the contrary evidence obtained during the investigation before reaching its conclusion.

> RECOMMENDATION 6: The Training Division should reconsider its recommendation on tourniquet training based on case-by-case differences, and should consult medical professionals regarding the circumstances under which the application of a tourniquet is advisable.

Damage to Uninvolved Property Owners

The reports indicate that one of Officer Romero's bullets apparently struck an uninvolved car parked on the street where the incident occurred. A number of jurisdictions have protocols whereby supervisory on-scene personnel would be tasked with identifying the owner of such a vehicle or other property and assertively reaching out to reimburse for any property damage. In our experience, proactively addressing collateral property loss by uninvolved persons as a result of police actions is consistent with principles of "good government," engenders good will among neighborhood residents, and actually serves to reduce later liability concerns.

> RECOMMENDATION 7: The Police Bureau should devise protocols assigning on scene supervisors the responsibility of identifying any property loss or damage as a result of police actions in critical incidents.

RECOMMENDATION 8: The Police Bureau should work with the City to devise a methodology to proactively reimburse any uninvolved persons who have suffered property loss or damage as a result of police actions in critical incidents.

April 16, 2014 ◦ Paul Ropp

Shortly before midnight on April 15, 2014, Police Bureau officers were dispatched to an audible alarm at a business that sells police and security uniforms and other equipment to law enforcement clients, including the Portland Police Bureau. As the first officer to arrive was getting close to the strip mall that housed the store, he noticed a large white SUV leaving the area and made a note of its license plate number. He then continued on to the store, where he noted someone had attempted to pry open the back door to the business.

Later in his shift, at around 1:30 a.m., the responding officer observed the same white SUV enter a parking lot in an area near the uniform store. That officer called for backup and made a plan to conduct surveillance at the store. When the SUV moved to the rear of the store, the officer requested additional resources (including a K9 unit), anticipating that the occupants of the vehicle were going to burglarize the store and he would need assistance to apprehend them. Six additional units responded, including two sergeants, John Holbrook and Norman Staples, Officer Jason Worthington, and K9 Officer Jeffrey Dorn.

The additional officers set up in various positions around the business, with one officer positioned in a location to see the suspect vehicle. They began discussing tactical options and planning for apprehending the suspects. Officers considered setting spike strips around the vehicle to prevent it from driving away, but one occupant remained in the SUV, making it impossible for an officer to place the spike strips without being detected. As the officers were still planning for various contingencies, two suspects came out of the store carrying duffel bags, loaded them into the SUV, and drove away. Officers briefly discussed the possibility of performing a box-in maneuver to stop the vehicle, but determined it would not be safe or effective in these circumstances.

Officers began following the suspect SUV on Barbur Boulevard, with Sgt. Holbrook in the lead position. When an additional three patrol cars had joined the effort behind him,[11] Sgt. Holbrook activated his lights to initiate a traffic stop.

[11] Police Bureau policy limits to three the number of police units to be involved in a vehicle pursuit. Exceptions to this three-unit maximum may be authorized in an "unusually dangerous situation," and authorization must be broadcast by the supervisor of the pursuit. Here, the fourth officer to join the pursuit wrote a report explaining his decision and failure to request authorization. He stated his belief that the burglary of a police supply store created additional risk, and stated that he did not want to tie up the dispatch lines with an authorization request. This decision and rationale did not receive scrutiny during the incident review process.

The suspect vehicle sped up as the officers pursued. The roads were wet from a recent rain, and the radio broadcasts indicate the vehicles reached the speed of 55 miles per hour, slowing down for turns until they reached Capitol Highway. The SUV continued until the driver attempted to make a sudden left turn, lost control and crashed the vehicle into a power pole. The pursuit lasted about 35 seconds. During the pursuit, two officers examined the rear of the store and confirmed that the suspects had broken into it.

Sgt. Holbrook was able to safely negotiate the turn, but could not stop in time to ideally position his car behind the suspect's SUV, so he swung around so his car was perpendicular to and pointing toward the passenger side of the suspect vehicle. Officer Worthington was just behind Sgt. Holbrook in the pursuit and stopped his patrol car several car lengths behind the SUV after it had crashed. Officer Dorn was the third police car in the pursuit. Anticipating that one of the suspects might try to run from the vehicle, he drove past the first two cars and angled his patrol car toward the SUV, where he could see the suspect later identified as Paul Ropp exit and begin to flee.

All the officers quickly exited their vehicles. Sgt. Holbrook approached the SUV to address its occupants while Officers Dorn and Worthington focused on the fleeing Mr. Ropp. Sgt. Holbrook and other responding officers arrested the two other occupants of the SUV without incident. Officer Dorn released his K9, Mick, from the car and began to run down the street in the direction they had seen Ropp flee. It took Mick a little distance to recognize the fleeing suspect, and when it became clear to Officer Dorn that Mick had acquired sight of Mr. Ropp, he released Mick to apprehend him. Ropp had run into a yard, in the area of the driveway, and Officer Dorn could only see his silhouette in what the officers described as very dark conditions.

Just as Mick reached Mr. Ropp, Officer Dorn heard gunshots and realized the suspect was firing at him. Officer Dorn was struck twice, once in each leg, in the upper thigh/groin. He tried to take cover behind a very short garden wall and returned fire at the suspect. Ropp's gunfire also struck Mick, fatally wounding him.

Immediately after he stopped his vehicle, Officer Worthington recognized that Officer Dorn was chasing the suspect and joined the pursuit to assist. He was still a little behind and off to one side of Officer Dorn when he saw Mick reach the suspect, saw muzzle flashes from Ropp's gun, and heard gunshots. He recognized that the suspect was firing a rifle. He returned fire, but then lost sight of the suspect as he looked for and moved to a position of cover behind a rock

column. He could see Officer Dorn, who told him he had been hit. Officer Worthington continued to visually scan the area for the suspect as other officers arrived and tended to Officer Dorn.

Mr. Ropp was struck once – a grazing shot to his head that did not penetrate his skull. He fled the area.

Officers reached Dorn and rendered medical care while coordinating the effort to move him to safety and get him to an ambulance. Officers also set up a containment area, activated SERT, and began a search for the suspect. They received assistance from a number of witnesses who saw the suspect in various locations. SERT officers ultimately located Mr. Ropp walking down a sidewalk, more than three and a half hours later and over two and a half miles away from the initial shooting scene. He surrendered without incident. He received immediate medical treatment for the gunshot wound to his head, which was not critical.

Mr. Ropp fired a total of ten rounds from an AR-15 rifle. Officers Dorn and Worthington fired nine and six rounds, respectively, from their 9mm handguns. None of the officers identified a gun in Mr. Ropp's possession as he fled the SUV, though Officer Worthington later said he believed he may have been carrying something.

Timeline of Investigation and Review

4/16/2014	Date of Incident
6/6/2014	Initial IA Investigation completed
7/2/2014	Training Division Review completed
10/8/2014	Case returned to Internal Affairs
11/14/2014	Amended IA case completed
12/29/2014	Commander's Findings completed
2/11/2015	Police Review Board convened

Analysis and Issues Presented

Tactical Decision Making

The Internal Affairs investigation examined a number of points of tactical decision making throughout this incident that were then analyzed by Training and the Commander. When the suspect SUV pulled out of the uniform store's parking lot and failed to yield to Sgt. Holbrook's activated lights, Sgt. Holbrook, with the support and approval of Sgt. Staples, initiated a vehicle pursuit. With the exception, as noted above, of having more officers in the pursuit than allowed under the Bureau's vehicle pursuit policy, the investigative and review process reviewed the pursuit thoroughly, and the sergeants and all involved officers clearly articulated the various factors and considerations that went into the decision to pursue – though the roads were wet from recent rains, the pursuit speed was never excessive, the roads were relatively straight, and the traffic was light. The pursuit lasted slightly more than 30 seconds.

At the end of the vehicle pursuit, Officers Dorn and Worthington pursued Mr. Ropp on foot. At the initiation of this very brief foot pursuit, both officers ran past the SUV with the still-undetained suspects inside, creating a significant risk for themselves. In addition to the threat posed by the suspects inside the car who easily could have targeted the officers as they passed, the officers ran downrange of the others involved in the vehicle pursuit, creating a potential crossfire scenario if those officers had engaged with the remaining suspects. Internal Affairs investigators addressed these issues with Officers Dorn and Worthington, who acknowledged the dangers but articulated their reasons for pursuing the suspect in the face of those risks. Officer Dorn understood his responsibility as the K9 officer, in conjunction with his dog, to chase and apprehend the fleeing suspect. Officer Worthington was more cognizant of the risks as he went past the suspects' car, and explained that he did not want Officer Dorn to be alone as he pursued the running suspect.

The Training review found the foot chase to be "generally acceptable but created identifiable risks." Training essentially accepted Officer Dorn's assessment of his role – that assuming the level of risk involved in sometimes dangerous foot pursuits is inherent in the position of K9 officer. The Commander's findings did not address this specific issue but found no violation of the Bureau's foot pursuit policy. This incident raises interesting questions about acceptable risk levels and the Bureau's expectations regarding officer safety. Nearly all of the involved officers commented at some point in their interviews about the need to apprehend

these fleeing suspects because of the dangerousness presumed by the fact that they had burglarized a police uniform and equipment store. Yet because no one specifically saw a gun in the car or on Mr. Ropp as he fled, they pursued him as they would an unarmed suspect, including using the dog to chase and apprehend. We do not presume to have the correct answer about whether the foot pursuit in this incident was the type of risk the Bureau should expect its officers to take, but it would have been preferable for the Commander to discuss the issue in his assessment of the incident.

Regardless of concerns about the foot pursuit, there can be little question about the officers' justification for shooting at the suspect. Internal Affairs investigators nonetheless thoroughly plumbed the question surrounding officers' backstop and concerns about potential crossfire in this residential neighborhood. All of these issues were thoroughly addressed in the Training Division Review and the Commander's Memorandum.

Role of Involved Sergeants

Two sergeants were among those who initially responded to this call, Sergeants Holbrook and Staples. They communicated from the outset about who would be the supervisor in charge. Because Holbrook was positioned to be involved in the pursuit as the lead car, they acknowledged Sgt. Staples as the incident supervisor, meaning he was ultimately responsible for authorizing the vehicle pursuit and directing tactical resources. He kept some distance from the pursuit while monitoring it over the radio. He arrived at the terminus of the pursuit seconds before the exchange of gunfire, acknowledged that Sgt. Holbrook had control of the suspects in the SUV, and then ran to Officer Dorn and administered first aid. When other officers arrived at Officer Dorn's position and took over first aid efforts, Sgt. Staples assumed the role of an AR-15 cover officer, looking out for any sign of the suspect emerging to re-engage. As additional resources arrived, he coordinated the effort to remove Officer Dorn from the scene and then turned attention to the eventual capture of Mr. Ropp.

Sgt. Holbrook's role in this incident was essentially the same as other officers. He positioned himself at the front of the vehicle pursuit, maintained that position even as multiple other cars joined the chase, initiated and led the high risk traffic stop, and ultimately detained the occupants of the SUV at gunpoint. When other officers arrived to take those suspects into custody, he joined with Sgt. Staples in coordinating the resources necessary to locate Mr. Ropp.

As we have said repeatedly in prior reports, sergeants on the scene of a tactical incident should take command and direct resources appropriately without engaging directly in a tactical role. In an incident we reviewed for our last report, Sgt. Holbrook assigned himself to be part of the communication team addressing a subject and ultimately used deadly force in the incident. In that case, as in this one, there were numerous other officers present who could have filled Sgt. Holbrook's tactical position had he chosen to maintain supervisory distance.

Despite our ongoing focus on this issue and repeated recommendations to address it, neither the Training Division review of this incident nor the Commander's Memorandum noted any concern with the tactical role assumed by Sgt. Holbrook and, to a lesser extent, Sgt. Staples. This is despite the fact that the Bureau's training instructs sergeants to be the team's decision makers and to work through their officers to resolve an incident rather than personally engage.

The Training review, however, was critical of the delay in establishing a staging area and setting a sufficient perimeter. Training does not link the slow response to the sergeants' inattention to these supervisory tasks, instead placing responsibility more generally with all responding officers. But it is impossible not to wonder whether a sergeant more singularly focused on maintaining a perspective on the entire incident rather than engaging in tasks better delegated to others could not have directed the establishment of a perimeter more quickly and effectively than what occurred here.

Investigation and Review

Timing of Officer Interviews

This was the second case where Internal Affairs investigators gave involved officers notice of a scheduled administrative interview on the morning of the shooting, and then made arrangements to sit in on the Detectives' voluntary interview that occurred just before the scheduled Internal Affairs interview. Internal Affairs investigators completed their interview immediately after the Detectives' interview. This was one phase in the evolution of events surrounding the so-called "48-hour rule" over the past several years. In this case, the scheduling of interviews stretched way past the 48 hour mark, so that the Bureau did not get an account from either involved officer until six and seven days after the shooting. While we are sensitive to the fact that Officer Dorn was seriously injured in this incident, such a long delay is certainly not ideal, as we have noted many times.

Delay in the Investigation and Review Process

At the time of this incident, the Bureau had recently begun observing a 180-day deadline for completing the administrative investigation and review process laid out in the City's settlement agreement with the Department of Justice. This case was completed in 327 days. It was so far outside the timeline largely because Bureau executives returned both the Internal Affairs investigation and the Training Division review to the respective divisions so that additional work could be done. Specifically, the Precinct Commander requested additional interviews of two involved sergeants, and an Assistant Chief requested that Training lengthen its discussion of backstop issues and the initiation of the foot pursuit, with an emphasis on the threat posed by undetained suspects in the SUV.

Police Bureau protocol, prompted by DOJ requirements, requires all those involved in the review process to meticulously document the reasons for any delay. In addition to complying with this protocol, many of those involved in the investigation and review also weighed in with suggestions about how to avoid such delays in the future. While missing the targeted deadline by 147 days is cause for concern, the Bureau's tradition of self-scrutiny serves it well in these circumstances, providing reviewers with an understanding of the reasons for the delays and some perspective on what the Bureau can do to correct noted problems.

The recommendations we make stemming from this case are discussed in greater detail in Section Two, Common Themes and Issues, below.

September 1, 2014 ◦ Denoris McClendon

On the morning of September 1, 2014, the Bureau of Emergency Communications started receiving dozens of 911 calls from motorists on I-84 reporting a man standing by the freeway who was pointing a handgun at them as they passed. Some callers believed they saw the man attempt to carjack passing cars.

A motorcycle officer was the first to arrive on scene. He stopped with his police lights on 700 feet or more from the man with a pistol. When he dismounted and shouted orders, the person, later identified as Denoris McClendon, pointed the pistol at him. The officer sought cover behind his motorcycle and watched Mr. McClendon climb over the concrete barrier between east and westbound lanes, point his gun at passing motorists, try to open the door of a stopped cargo truck, pace back and forth, and then climb up a low embankment onto railroad tracks running adjacent to NE Fremont Street and a residential neighborhood. The officer broadcast these observations and requested immediate back up.

Other officers began arriving and climbed the embankment, as did the motorcycle officer. Mr. McClendon walked out of sight beyond the bushes on the embankment. Two officers also reported that McClendon pointed his gun directly at them. Other officers arrived in the area along a residential street on the other side of the railroad. They spotted McClendon and shouted at him to drop his gun and get down, orders he ignored. He was observed by some of the officers pointing his gun and appearing to search for them in the foliage. Officers began to stop freeway traffic in both directions along with the traffic on Fremont Street. Other officers arrived at the scene including Officer Michael Honl, who carried his service shotgun.

Mr. McClendon moved back and forth along the grassy area near the bushes and the residential street while most officers were able to get intermittent glimpses of him through the foliage. Two sergeants en route also began to broadcast orders to take containment positions in the area, requested a K9 unit, and announced the movement and direction of Mr. McClendon. During this period, Officer Honl took a position with other officers along the embankment that paralleled I-84 and looked down onto Fremont Street. He heard other officers spotting McClendon or giving him orders. He moved toward and along the line of bushes to get a view of the subject. Through a break in the bushes, he looked toward Fremont Street and saw McClendon approximately 65 yards away pointing the handgun in a direction where he believed officers were positioned. He fired one round of buckshot with

his shotgun, which he concluded had not hit Mr. McClendon, who kept walking. Officer Honl followed in parallel and, a few seconds later, through a second break in the bushes, saw McClendon clearly again still pointing his gun in the direction of officers. He fired a second round, which caused McClendon to fall to the grass after a couple of steps. An officer who observed Officer Honl shoot, broadcast "shots fired," over his radio.

McClendon spent the next 65 minutes raising himself on his elbows and yelling things such as "kill me," "I just want to die," and "shoot me in the face, you pussies," at the police officers in the area. His gun lay on the grass approximately six feet from him. He referred to it as a "BB gun" but stated that he also had a "real gun" concealed on his person. He did not comply with orders shouted at him to roll away from the gun or keep his hands visible. During this period, one sergeant formed an arrest team, and positioned it to take Mr. McClendon into custody and provide medical aid, but the precinct captain, who had taken over the scene shortly after the shooting, decided that his continued taunting and refusal to comply with orders made the arrest too risky and decided to wait for SERT. SERT arrived, devised a plan involving armor and possible use of a K9, and took McClendon into custody without incident.

Mr. McClendon was taken to the hospital and treated for the gunshot wounds to his legs. The gun that he had carried turned out to be a black metal BB gun. He had no other weapons.

Timeline of Investigation and Review

9/1/2014	Date of Incident
11/4/2014	Detectives' Investigation completed
11/19/2014	Training Division Review completed
12/1/2014	Internal Affairs Investigation completed
12/21/2014	Commander's Findings completed
2/11/2015	Police Review Board convened

Analysis and Issues Presented

Scene Supervision and Communication

Two sergeants arrived and assumed supervisory duties at the scene before the shooting occurred. The bushes, the embankment and a cyclone fence created physical and visual barriers that complicated the scene and the ability of officers to see each other and to locate Mr. McClendon. Some officers, trying to get a glimpse of his position, found themselves in the potential line of fire and had to be warned by other officers or a supervisor to change location or risk being in the backdrop of officer fire. Other officers reported receiving pieces of the sergeants' updates but having to infer the location of McClendon and their partner officers from sounds and from the partially observed movements of officers. At least 13 officers and sergeants ended up as direct participants and witnesses in the operation before the shooting occurred. While the sergeants acted quickly and divided the work of supervision, the Training Division pointed out that neither was in control of command and communication and they failed to make and communicate a plan. The first sergeant to arrive also failed to coordinate the arrival of subsequent officers, increasing the potential danger to them and the time needed to achieve effective containment of Mr. McClendon.

Delay of Medical Attention

Within seconds of the shooting, emergency medical aid was requested and told to stage near the scene, but medical personnel were not allowed into the scene until one hour and ten minutes later. A sergeant at the scene suggested that the relevant factors that justified the delay were that Mr. McClendon did not seem to have a life-threatening injury, was alert, did not complain about pain, lacked visible injuries and communicated constantly with officers. The sergeant's surmise turned out to be accurate. McClendon had been hit in the leg and buttocks by two pieces of buckshot and his injuries proved to be minor. Nevertheless, what was known at the scene was he had been shot and was not getting to his feet.

Timely Broadcasts

We have pointed out in past reports deficiencies and delays in broadcasts by field supervisors to update personnel at the scene about the positions of all officers. Conversely, in this incident, officers' positions were frequently updated and broadcast by the two on scene field sergeants. This task was both difficult and vital because of the physical and visual obstacles and the frequently moving containment of McClendon that supervisors strove to maintain. While as noted

above, the Training analysis identified concerns about command and devising a plan, the supervisors did work to keep responding officers apprised of McClendon's location and those of fellow officers.

Investigation and Review

Tactics Review

While concluding that the first two sergeants at the scene employed generally sound and effective tactics, the Training Division also focused on the sporadic, unevenly distributed information emanating from the initial responding sergeants, specifically citing deficiencies in guiding incoming officers and in failing to formulate a plan on how best to respond to the threat posed by Mr. McClendon. The reviewing Commander and the Police Review Board did not take up this issue regarding the sergeants, focusing rather on their role in effectively supervising the dynamic moving containment of the suspect.

The review also appropriately focused on the use of deadly force and the danger to others in the area. Officer Honl shot in defense of others after inferring from the actions of McClendon and what he could determine about the positions of other officers that he was taking direct aim at officers with his pistol. Defense of others is a clear justification for using deadly force according to both the case law and Police Bureau policy. The challenge here was to determine how reasonable Honl's inference was that other officers were in eminent danger given his limited knowledge of their positions and to weigh that against the danger that his shooting might pose to McClendon, nearby officers and civilians. The Training Division concluded that Officer Honl's decisions to fire his shotgun twice were "generally acceptable but created identifiable risks," to other officers and civilians, given that he fired through holes in the foliage, toward a background from which motorist cross traffic might not have yet been cleared, and directly over a homeless encampment a few feet below his shooting trajectory that he failed to see through the foliage.

There is, however, an implication from the officer's rationale for shooting that was not explored. Officer Honl shot at McClendon because he saw him repeatedly aim his gun in directions where he believed fellow officers to be. Other officers indeed perceived McClendon's roving gun muzzle as a deadly threat, but it is unclear from their reports and interviews whether those officers had adequate cover or had taken advantage of the available cover. Neither Detectives nor Internal Affairs interviews established this information. Without it,

it is not entirely clear how the Training Division could infer the urgency or necessity of Officer Honl firing to protect other officers. Additionally, if officers had not taken advantage of available cover, then that raises the other unexplored issues of why not and whether their actions complied with tactical training. A few of the other officers at the scene considered firing at McClendon, similarly because he appeared to be searching for and pointing his gun at officers through the foliage, but each decided not to shoot because of an unsafe backdrop that contained civilians in vehicles. Officer Honl explained that, given the location from which he was shooting, he believed that his backdrop was the ground and was free of civilians or other officers. Training Division, the reviewing Commander, and the Police Review Board all agreed that this was a reasonable conclusion, but never addressed the degree to which other officers were in grave danger and why.

Training Division did address the fact that Officer Honl failed to broadcast his shots fired. This was rendered an arguably minor deficiency since another officer who saw the shots immediately broadcast "shots fired," but the field sergeant who was nearby had to ask, "Who shot?" to the officers in his vicinity before Honl stated that he had fired. Moreover, the shooter officer's failure to broadcast for the benefit of more distant officers that he had fired his weapon was a missed opportunity to indicate that the gunfire was not coming from the suspect. Some of those officers later stated that they did not know whether the suspect had fired the shots or not. The fact that McClendon's weapon looked like a standard semi-automatic pistol but turned out to be a BB gun points out the added danger of officers misperceiving that they were being fired upon by the subject.

Training also criticized the use of conventional buckshot rounds in this situation, pointing out that a rifled slug would have been more accurate and effective given the long distance to the suspect. Training, however, did not criticize Officer Honl's choice of ammunition but rather the Bureau's policy that an officer must receive approval from a supervisor before shooting a slug with a shotgun. The reviewing Commander addressed this issue, recommending that the shotgun operator have the discretion to use slug rather than a buckshot round when circumstances call for it. The Police Review Board also agreed with Training that the policy should be evaluated. The Chief subsequently directed the Training Division to make a recommendation concerning the issue. The Bureau ultimately modified its shotgun ammunition policy to allow a shotgun operator to load and use whichever ammunition – buckshot or slugs – seem tactically appropriate to the circumstances.

Walk Through Procedure

Shortly after an officer-involved shooting, Detectives conduct a walk through of the scene to familiarize themselves with the area and obtain valuable information. They are often accompanied by crime scene technicians, members of the District Attorney's Office and, if he or she will consent, the involved officer or officers. In this instance, Officer Honl accompanied them but made no statements, which is allowed under Police Bureau policies. The officer's attorney, however, who was also participating, did make statements that "identified Officer Honl's field of fire and the approximate area where he was standing when he fired." While surely done with good intentions, this procedure, if it is common, creates potential problems. The information will tend to guide the exploration of the investigators and crime scene techs and may color their evaluation of the issues. Since the attorney was not a witness, it will not be possible to know where the information comes from, though there will be a strong, perhaps inaccurate tendency to assume it comes straight from the involved officer/client with no editorial inflection from the attorney. The information is not evidence and its accuracy will not be known until much later in the investigation.

> RECOMMENDATION 9: Investigators should not request or permit attorneys who accompany their clients on a walk through to offer "evidence" about the incident.

Mental Health Infrastructure

At about 8:00 p.m. the evening before Mr. McClendon was shot and arrested, Police Bureau officers had responded to a call from his grandmother who had asked that officers come to their residence to assist her with Mr. McClendon. He had reportedly been in the backyard for a good part of the day swinging a wooden dowel at shrubbery, proclaiming to be looking for the FBI. He had broken his left arm and right wrist a few days earlier and had since torn the casts off of both arms and torn out stitches. The officers arrived to perform a "welfare check," and determined that Mr. McClendon could not care for himself. They contacted Project Respond,[12] arranged to have him transported to the hospital, and followed to place a "police officer hold" on him for mental observation. That was accomplished twelve hours before McClendon appeared at the side of the freeway pointing a gun.

---

[12] Project Respond is the mobile mental health crisis response team for Multnomah County. Its implementation, procedures and interaction with the Portland Police Bureau are described in our May 2012 Report and in our January 2016 Report.

The contact with Mr. McClendon and the attempt to get him mental health assistance was noted by investigators, but they did not follow up to see how long he had remained in the hospital, whether he had received any treatment and why he had been discharged so quickly.

> RECOMMENDATION 10: The Police Bureau should consider following up in this case and cases of this nature where an arrestee has recently been put on a 72-hour hold through the intervention of law enforcement. Some investigation into the circumstances of the medical authorities' decision to release the subject early could provide valuable insight into the advisability of that decision and the Bureau could develop a diplomatic and constructive method to provide medical authorities and Project Respond with this potentially valuable feedback.

Timeliness

The Bureau exceeded its 180-day time limit for completion of the investigation of this incident by nine days. Several units contributed to this delay and thoroughly documented the reasons for the delays. Training Division, for instance, went 19 days over their time limit. The interviews of the witness officers and sergeants took place on the day of the incident. Detectives and investigators interviewed Officer Honl four days after the incident. The delays were not particularly conspicuous but cumulatively they can undermine the deadlines that help make the investigative process efficient and effective. As we have noted in previous reports and elsewhere in this report, the practice of interviewing officers days after the incident is not consistent with best investigative practices.

February 17, 2015 ◦ Ryan Sudlow

Officers assigned to the Tactical Operations Division were tasked with arresting Ryan Sudlow, a known gang member who had outstanding felony warrants for probation violation and attempt to elude. The operation was led by members of the Metro Gang Task Force, which is a joint operation with the FBI that focuses on long term investigations involving gang organizations. The Task Force also works closely with the Gang Enforcement Team and the Gun Task Force. This operation also involved Air Support and a K9 officer.

A Task Force officer developed a plan to take Mr. Sudlow into custody by conducting a box-in maneuver when Mr. Sudlow stopped at a convenience store following a drug transaction set up by a confidential informant. Officers made the decision to attempt a box-in rather than conduct a typical traffic stop because Mr. Sudlow had a history of running from officers and had reportedly told their informant that he knew he had a warrant and would flee before allowing himself to be apprehended and returned to jail.

The plan involved undercover surveillance officers who would track Mr. Sudlow's movements as well as designated uniformed officers on a custody team who would conduct the box-in maneuver. The Task Force's supervising sergeant and lieutenant approved the plan, and the assigned officer briefed those involved in the operation. The operational order expressly called for a box-in by the custody team without specifying who would be in which position, recognizing that the situation would be fluid and roles could change. At the briefing, officers discussed tactical approaches to the box-in maneuver, as well as other intelligence information and tactical considerations. Given Mr. Sudlow's history of fleeing and because they knew his identity and likely could locate him at another time, they agreed they would not engage in a vehicle pursuit if the box-in failed. If he fled on foot, they had a K9 officer on the team and planned to set a perimeter and use the dog to track him. Officers also discussed the fact that Mr. Sudlow was not known to own or possess a gun.

Two sergeants shared supervisory responsibility during this incident. Sgt. Jose Gonzalez supervised the undercover surveillance team and Sgt. Ken Duilio supervised the custody team. Participants understood that Sgt. Gonzalez was the overall supervisor in charge of the mission, though Sgt. Duilio had responsibility for the operation of his team and understood he had the ability to make an independent judgment about the advisability of any particular order.

When the drug transaction fell through because of safety concerns regarding the informant's identity and security, officers transitioned to a more straightforward plan to arrest Mr. Sudlow. They maintained their intended strategy to box him in, and planned to wait until he stopped in a parking lot that they believed would allow them to safely perform that maneuver. A surveillance team set up outside his home and followed him when he emerged and got into his vehicle at about 6:20 p.m., accompanied by a female companion in the passenger seat. After a short distance, Sudlow pulled into a gas station and up to one of the pumps to buy fuel.

The gas station had four islands, with a pump on each side. There was a car at the island in front of Sudlow's vehicle, and shortly after Sudlow arrived, another vehicle pulled up at the pump on the other side of the island. The station was generally described as "more busy than not." A gas station attendant went to the passenger window of Sudlow's vehicle.

Sgt. Gonzalez was focused on the mission to apprehend Sudlow and viewed the gas station as a "perfect" location because he was contained on one side by the pump and would have to turn his engine off to fuel up, limiting his ability to escape. He gave the go-ahead for the custody team to perform a box-in, and Sgt. Duilio gave the order to execute it. Officer Charles Asheim was the driver of the first car; he pulled up to Sudlow's vehicle at an angle and pinned the driver's door. He and his partner quickly exited their patrol car. Sgt. Duilio drove the second car, and pulled directly behind Mr. Sudlow. The third car pulled in next to Sgt. Duilio's car, positioned slightly behind Officer Asheim's vehicle.

Mr. Sudlow started his car and accelerated in reverse, then forward, hitting Sgt. Duilio's car, then Officer Asheim's. Officer Asheim, positioned at the driver's doorframe of his patrol vehicle, reported seeing a change in the expression on Mr. Sudlow's face after he had rammed the patrol cars, as if he realized he would not be able to escape. Asheim believed Sudlow was reaching for something, gave commands for him to show his hands, and then said he saw a black object in Mr. Sudlow's hand. Believing it was a gun, Officer Asheim fired one round at Mr. Sudlow. The bullet struck the vehicle's windshield and ricocheted off, striking a metal support pole, then traveled vertically and struck the station's overhead canopy. The round was recovered at the opposite side of the gas station. No one was struck. No gun was recovered from Sudlow's vehicle, nor was there any mention in the file of an object resembling a gun. The shooting unfolded so rapidly that other officers were either still in their vehicles or just exiting when Officer Asheim fired his weapon.

After the shot was fired, Mr. Sudlow showed no further sign of resistance. Officers evacuated all civilians from the gas station, formed a custody team with designated lethal and less-lethal options, and formulated a plan for removing Mr. Sudlow and his passenger from the car. He surrendered and was taken into custody without further incident. Neither he nor his passenger was injured.

Timeline of Investigation and Review

2/17/2015	Date of Incident
4/8/2015	Initial Internal Affairs Investigation completed
4/13/2015	Initial Training Division Review completed
5/14/2015	Initial Commander's Findings completed
8/25/2015	Internal Affairs Addendum completed
9/22/2015	Revised Training Division Review completed
10/23/2015	Commander's Findings Addendum completed
12/14/2015	Police Review Board convened

Analysis and Issues Presented

Box-In Maneuver

The "box-in" maneuver, as the name makes clear, requires officers to position their patrol vehicles in a way that blocks a suspect's ability to move his car. It is a useful technique for preventing potentially dangerous vehicle pursuits but carries its own set of significant risks. The maneuver requires officers to pull directly in front and to the side of a suspect vehicle, putting themselves at a tactical disadvantage if the suspect has a gun and the intent to engage the officers. When it is a two-person patrol car, the officer on the passenger side is at a particular disadvantage. While some police agencies expressly prohibit officers from boxing in a suspect vehicle, the Bureau teaches it as an acceptable technique in certain circumstances. The Bureau's training acknowledges the risk to officers

inherent in the maneuver, and instructs officers to be cognizant of these risk factors when deciding whether, when, and how to employ the tactic.

Planning and Supervision

Officers initiated the box-in on Mr. Sudlow's car at a busy gas station just before 6:30 on a Tuesday evening. There were numerous people and other cars present, including an occupied car directly in front of Mr. Sudlow's, and one on the opposite side of the island also getting fuel, as well as a gas station attendant standing at the front passenger window of Mr. Sudlow's car. That attendant had to step back to avoid being hit by Mr. Sudlow's car when the impact from Officer Asheim's car pushed it toward him, and, before he was fully aware of what was happening, briefly wondered if Officer Asheim was pointing his weapon at him when the officer was in fact drawing down on Mr. Sudlow. Nonetheless, Sgt. Gonzalez viewed this as a "perfect" location and a "best case scenario" for taking the suspect into custody. He stated that he was so focused on the positioning of the patrol cars and the location of the suspect's vehicle that he didn't notice or remember seeing other civilian cars at the pumps. Sgt. Duilio was more aware of the other individuals, and noted his concern about their presence, but believed they could safely complete the operation.

The initial Training Review[13] found the box-in maneuver to be inconsistent with training, largely because of the location and the risks created for the number of civilians at the gas station. That version of the Review faulted the sergeants and officers for being so "locked in" on the plan to box-in Sudlow that they lost sight of the bigger picture and the nature of the immediate surroundings.

An addendum to the initial Training Review acknowledged the tactical disadvantages of the gas station, including the possibility that any gunfire could ignite fuel, as well as concern over Sgt. Gonzalez's belief that the location was perfect, but nonetheless concluded without further explanation that the decision to proceed with the box-in at that time and place was reasonable, if not ideal.

The Commander's Memorandum expressed a finding that the box-in maneuver was out of policy based on the conclusion that "the potential for injury to others outweighed the need to apprehend this fugitive at this particular time and location." The Police Review Board (PRB), however, found the decision to

[13] See below for discussion of the circumstances around the preparation of an addendum to the Training Review.

execute the box-in to be in policy, but called for tactical debriefings for Sergeants Gonzalez and Duilio on this issue.

The memo from the PRB facilitator laying out the Board's recommended findings does not acknowledge the Commander's finding that the box-in was out of policy, nor does it address the arguments raised by the Commander as the basis for his finding, namely that the situation presented too great a risk to members of the public. Those concerns for public safety may very well have been discussed during the PRB proceeding, but the failure of the findings memo to even mention them – let alone present an argument sufficient to overcome them – is a significant shortcoming that undermines the purpose and mission of the Review Board.

> RECOMMENDATION 11: When a Commander makes a finding that an employee's performance is out of policy, the Police Review Board should be required to expressly state any reasons for its own finding that diverges from the Commander's view.

Execution of Box-In Maneuver

Training on the box-in maneuver calls for the first and second patrol cars to make contact with the front and rear bumpers of the suspect vehicle (unless there are natural barriers to block the suspect's path) while the third vehicle pins the driver's door. Here, because there was a car positioned at the pump in front of Mr. Sudlow's car, officers could not pin the front of his car in, so Officer Asheim, the first car on scene, angled in and pinned the driver's door while Sgt. Duilio made contact with the rear bumper. Had the civilian vehicle at the other pump pulled away at that moment, Mr. Sudlow could have driven straight out. Had Mr. Sudlow chosen to ram that vehicle in an effort to flee, its occupants could have been seriously injured.

For these reasons, the initial Training Review found the execution of the box-in to be inconsistent with training. The amended review noted that the box-in was not ideal, but recognized that Officer Asheim's options were limited by the location and that decisions he made about the positioning of his patrol car were dictated to a large degree by his concern for his partner's safety. The Review ultimately called the box-in execution generally acceptable despite identifiable risks. However, unlike the initial Review, the amended review found the planning stage of the operation to be inconsistent with training because of the officers' failure to

cover proper box-in techniques when the tactic was discussed during the operational briefing.

The Commander's Memorandum found Officer Asheim's performance to be in policy, but recommended a tactical debrief on issues surrounding the box-in. The PRB concurred and likewise recommended a debriefing, which the Chief ordered.

Use of Deadly Force

Officer Asheim fired at Mr. Sudlow because he reported seeing a black object that he perceived to be a gun in his hand.[14] The review documents accept this characterization and focus on Asheim's positioning and his backstop.

When Officer Asheim fired, he was at an angle to Mr. Sudlow's windshield, and there was an occupied vehicle on the other side of the gas station pumps, a gas station attendant in the vicinity, and a passenger in Mr. Sudlow's vehicle. The original Training analysis concluded that Officer Asheim's backstop was "almost a worst case scenario." The bullet ricocheted off two surfaces before it landed harmlessly on the ground. In addition to highlighting the inherent danger in choosing to take someone into custody in a busy public place, the bullet's trajectory raised questions about Officer's Asheim's angle as he fired at Sudlow.

Though not explicitly a topic of training at the time, both versions of the Training Review acknowledge that officers generally should be aware that standard 9mm ammunition fired at a windshield at an angle is likely to skip off the windshield rather than penetrate, and even if it penetrates, it is not likely to travel in a predictable path. The initial Training Review, therefore, found Officer Asheim's use of deadly force to be inconsistent with training, or to create an unnecessary or serious risk. The revised Training Review used additional statements made by Officer Asheim in a follow-up Internal Affairs interview regarding his awareness of his backstop to explain the decision to change this conclusion to generally acceptable despite identifiable risks. The Training Division recommendations included improving its course of instruction about the ballistic characteristics of ammunition relative to striking glass.

The Commander's Memorandum found Officer Asheim's justification for the use of deadly force to be within policy and his overall performance to be within the range of acceptable performance, but recommended a tactical debriefing. The PRB's recommendation was consistent with this.

[14] None of the other officers or witnesses reported seeing a gun, though they likely were not in a position to do so.

Role of Involved Sergeants

Here, Sgt. Duilio was tasked with supervising the custody team but assigned himself a role as the number two car in the deployment of the box-in. As we have said repeatedly, it is not ideal for sergeants on the scene of tactical incidents to directly engage rather than maintaining distance, taking command, and directing officers and resources appropriately. The initial Training Division Review noted that Sgt. Duilio's participation in the operation "somewhat limited" his ability to supervise, but did not make a specific finding or recommendation on this point. Neither the final, revised Training Review nor the Commander's Memorandum addressed this issue.

Investigation and Review

This incident occurred in the City of Gresham, so the Gresham Police Department assumed the lead role in the criminal investigation, assisted by Bureau Detectives and other members of the East County Major Crimes Task Force.

The various tactical issues raised by this incident – those discussed above, as well as issues relating to supervision, coordination, and communication regarding some changes in personnel mid-operation, and issues regarding weapons deployment after the shooting – were thoroughly investigated and discussed by Training and the Commander. As noted above, the Police Review Board's discussion of the issue was disappointing in its failure to specifically address concerns raised in the Commander's Memorandum.

Viewing of Video by Involved Officer

The gas station's surveillance cameras captured some video of this incident, as did Air Support. The Gresham detectives in charge of the criminal investigation allowed Officer Asheim to view these videos prior to interviewing him. This conflicts somewhat with Police Bureau investigative practice,[15] and also is at odds with what we view as best practice. As we discuss in greater detail in the "Common Issues" section, it is best to take statements from all involved before allowing them to watch any recorded footage, and then give the officers the opportunity to supplement their statements or respond to follow-up questions after they have had the opportunity to see the video.

[15] The Bureau generally does not permit officers to view video prior to making a statement, but decisions are made on a case-by-case basis.

Timing of Officer Interviews

This case also followed the protocol of having Internal Affairs investigators sit in on the Detectives' interview of the involved officer and then conduct a compelled administrative interview immediately after. As we have noted throughout this report and previous reports, the fact that Gresham Detectives had to wait three days before interviewing Officer Asheim does not comport with best investigative practices.

Delay in the Investigation and Review Process

The investigation and review of this case took 321 days, 141 days past the 180-day deadline laid out in the City's settlement agreement with the Department of Justice. The delay was due largely to a convoluted review history stemming from a staffing change at the Training Division. After the Training Review and Commander's Memorandum had been completed, but before the case was reviewed by the Police Review Board, the author of the Training Review retired. The newly assigned Training Lieutenant believed that additional information was needed and requested that Internal Affairs conduct two additional interviews. The scheduled PRB hearing was postponed while Internal Affairs did this work, the Training Review was re-drafted, and the Commander prepared an addendum to his findings memorandum.

Training Division Review

The revised Training Review differed in meaningful ways from the initial one authored by the now-retired Lieutenant. The delay resulting from the shift in views at Training is concerning, but more troubling is the fact that the division's perspective on a given incident can change so significantly with one retirement. The original Training analysis found both the box-in and the shot fired at Mr. Sudlow to be "not consistent with training or created an unnecessary or serious risk" (following the standard rating scale used by Training for these purposes). The revised review found these decision points to be "generally acceptable but create identifiable risks."

On the flip side, the new review found aspects of the planning and execution of the mission – focusing on inadequate planning and briefing of the box-in maneuver – to be inconsistent with training, where the original review had determined them to be generally acceptable despite identifiable risks.

Both versions of the Training Division Review in this case were thoughtful and detailed. The fact that two different authors reached different conclusions on

some key points (at least as to a matter of degree), though, could be either an indicator of a larger structural problem within Training, or simply evidence that this case presents a close judgment call about which reasonable minds can differ. The written documentation we have does not provide any evidence that the Training Division or Bureau executives examined this issue to determine whether there are lessons to be learned to prevent this type of conflict within Training in the future. Although we were told the specific scenario presented by the retiring lieutenant is a rare occurrence, we are aware of times when the analysis of a critical incident has generated significant differences of opinion among trainers. To ensure that the training being disseminated on a given subject is clear and unambiguous, we recommend the Bureau adopt a procedure for addressing such disagreements.

> RECOMMENDATION 12: The Bureau should develop a process for review and evaluation of situations in which the analysis of a critical incident generates significant disagreement among members of the Training Division as to whether an officer's actions were consistent with training.

May 17, 2015 ◦ Michael Harrison

On Sunday, May 17, 2015, at 2:15 p.m., the Bureau of Emergency Communications received a 911 call from a woman concerning Michael Harrison, her 47-year-old son, who she discovered cutting his wrists with a knife in her home on SE 14th Avenue. She reported that he had just walked out of the house heading south. Emergency Communications dispatched Police Bureau officers from the Central Precinct along with emergency medical responders to locate him.

Five minutes after the initial call, another woman called 911 from her residence on SE Boise Street, two blocks away from the first caller's residence. She said a man she did not know had just walked into her home with blood all over his hands and holding a bloody knife. She told Emergency Communications that she was hiding in the house with her six-year-old daughter and six-year-old niece. Additional Central Precinct officers were dispatched to that location.

Emergency Communications broadcast the conclusion that both calls probably concerned the same suicidal man. Hearing this, the original two officers dispatched to the first location, went straight to the new burglary location instead.

En route, one of the officers realized that most of the shift officers, including the one certified to use the less lethal shotgun, were occupied at another call, so she asked for a sergeant with a less lethal shotgun. Pursuant to the request, Sergeant Martin Padilla headed for the location. While en route, he requested a K9 unit be sent to the scene.

The two officers arrived at the Boise Street address first and got the woman and the two children safely out of the garage where they had taken refuge. Officer Raelynn McKay and Sgt. Padilla arrived at the same time from the staging area one block away from the house, and McKay said she would act as lethal backup to his less lethal shotgun should he need to use it. The sergeant sought a briefing from the first two officers and began to take control of the scene by assigning containment positions to the officers present. He learned that the woman and children were safely out of the house, that the apparently suicidal suspect appeared to be the only person in the house and that the woman had said that there were no firearms in the house.

He told an officer to take a position at the north corner of the house and he walked to the area of the street directly opposite the front door. An officer told him that Mr. Harrison had been seen looking out windows.

Sgt. Padilla had a strong belief that the other day shift sergeant, Sgt. Hull, would be there soon. He had not requested the second sergeant but had worked with him for a long time and "knew" that he would be on his way. Within minutes, Sgt. Hull did, in fact, arrive just as Mr. Harrison opened the screen door, yelled something angry and incomprehensible, then slammed it shut.

When the second sergeant arrived on scene, he began directing positions for new officers arriving at the scene. The two on scene sergeants had yet to communicate with each other. Sgt. Hull later related that he was most concerned with finding out more about the house and containing the subject within it. A few seconds later, Mr. Harrison opened the front door again.

At that moment, Sgt. Padilla was standing near the south curb line of narrow Boise Street directly in front of the house's front door, with Officer McKay a few feet to his right and a newly arrived officer to his left. He observed Mr. Harrison, who "had blood all over his arms" begin to move rapidly down the two short flights of steps in front of the house. He ordered Mr. Harrison, whose arms were down, to put his hands up. Harrison paused between the flights of stairs, then raised his hands toward Padilla with a knife in his right hand, holding it pointed straight ahead. Harrison then began to run down the second set of stairs and into the street where Sgt. Padilla and Officer McKay had backed up.[16]

When Mr. Harrison reached the bottom of the stairs, Sgt. Padilla pulled the trigger on his less lethal beanbag shotgun, heard only a "click" and realized that he had not yet chambered a round, rendering the firearm unable to fire without further manipulation. He immediately "racked the slide" and fired at Mr. Harrison's center mass. He saw the round hit the suspect "somewhere in the chest, abdomen area."

Officer McKay, observing that Sgt. Padilla's less lethal round had no effect on the suspect, started firing her pistol at him when he was "a couple" of feet from Sgt. Padilla to try to stop him from harming him. Harrison then turned in her direction and began to move rapidly toward her, holding the knife in front of him and yelling. She fired several more shots and he fell to the grass in front of the house directly across Boise Street.

Sgt. Padilla's perception of the sequence of the shooting was consistent with Officer McKay's. He believed that Mr. Harrison was about ten feet from him

[16] Neither McKay nor Padilla described themselves as backing up during Harrison's advance, but civilian witnesses made this observation.

when the beanbag round made contact. At the same moment or slightly after, he perceived that Officer McKay started firing her pistol at Mr. Harrison. Mr. Harrison slowed down, hunched forward and kept moving as Sgt. Padilla and Officer McKay moved to either side away from Harrison who passed between them and collapsed "just over the curb line."

Officer McKay had struck Mr. Harrison with three of the seven rounds that she fired. Sgt. Padilla broadcast the shooting and informed dispatch that they would need the emergency medical team, which he knew was already staged nearby in response to the original call. Sgt. Hull then removed Officer McKay and Sgt. Padilla from the scene and designated an arrest team to secure Mr. Harrison.

Officers patted the suspect down for weapons and handcuffed him. Sgt. Padilla broadcast a request for the medical team to come in. When Mr. Harrison was loaded into an ambulance, Sgt. Padilla "dialed himself completely out of giving directions to other officers," because he had been involved in the use of force and knew that Sgt. Hull should take over. He went to sit in a police car.

Sometime after Mr. Harrison was taken away by ambulance, a witness officer noticed a kitchen knife with wet blood on both the handle and the blade located on a gravel walkway. The knife was approximately eight inches long including the handle. Mr. Harrison had taken it from the kitchen of the Boise Street house.

Mr. Harrison was treated at a nearby hospital for three gunshot wounds and self-inflicted knife wounds to his wrists and torso. He survived his injuries. Mr. Harrison was indicted by a Grand Jury for burglary and unlawful use of a weapon as felonies and two counts of misdemeanor menacing.

Timeline of Investigation and Review

5/17/2015	Date of Incident
6/5/2015	Grand Jury Proceeding
7/6/2015	Training Division Review completed
7/10/2015	Internal Affairs investigation completed
8/3/2015	Commander's Findings completed
9/10/2015	Police Review Board convened

Analysis and Issues Presented

Role of the Sergeants

Sgt. Padilla knew when he first heard the call out for a sergeant with a less lethal shotgun that he would be called upon to have an active role in the tactical response rather than act solely as a scene supervisor. He contemplated this en route and concluded that the necessity for a second, strictly supervisory, sergeant would be satisfied by Sgt. Hull whom he knew well and believed would be heading for the scene. He did not specifically request Sgt. Hull's presence, but he guessed correctly that he would respond. Sgt. Hull arrived a few minutes after Sgt. Padilla, witnessed the shooting, was able to quickly take control of post-shooting procedures, and because he was a witness, to hand control over to a third sergeant who arrived. It is unlikely that things would have transpired differently if Sgt. Padilla had called Sgt. Hull before arriving at the scene. Nevertheless, as a matter of standard procedure, it would seem to be preferable for a supervisor who has been called to a scene to potentially act in a tactical role to notify another supervisor of this and specifically request a response.

It is also important to acknowledge the rapid development of this incident and the short distances involved. Harrison opened the front door and yelled something less than two minutes after Sgt. Padilla's arrival. The sergeant broadcast that he had just seen the suspect who had gone back into his house. Thirty seconds later he broadcast that shots had been fired. Two minutes after that, emergency medical personnel were called in to give aid. Boise Street in this area is less than thirty feet across.

Use of Less Lethal Shotgun

Sgt. Padilla was trained and certified in the use of the bureau's authorized less lethal shotgun. The shotgun fires flexible "bean bags" designed to stop an assailant at a relatively short distance without killing him. The firearm can hold up to seven rounds, six in the stock and one in the chamber ready to fire. It also holds a reserve of four rounds.

The less lethal shotgun is carried in the police vehicle loaded but without a chambered round for safety reasons. The Training Division instructs officers trained in the less lethal shotgun to chamber a round when the shotgun is removed from the police vehicle rather than wait until some future moment when observations or circumstances appear to call for the weapon to be ready for use. Sgt. Padilla reported that he was unaware of this doctrine, a training lapse that is

arguably more significant than forgetting to chamber the round. The Training Division identified his mistake as possibly creating an unnecessary risk.

Sgt. Padilla's lapse also suggests that the small number of less lethal shotgun operators in the Bureau may lack sufficient contact with Training and with one another to ensure familiarity with the policies specific to the weapon, including the specific instruction about chambering rounds.

In this incident, the issue of the non-chambered round may seem academic because of the very few seconds available to the sergeant to fire the shotgun, but it raises an important point about the general efficacy of the beanbag rounds. Veteran operators and trainers of this weapon have observed that there is sometimes a cumulative effect of beanbag impacts so that the second or third round rather than the first is the one to bring the suspect down. Because Sgt. Padilla's first trigger pull was an empty chamber, he had time to fire only one round. When that round did not neutralize the fast charging threat of Mr. Harrison, Officer McKay fired her conventional gun as the lethal backup.

The circumstances of this incident may also suggest that the Bureau has a lower than optimal number of less lethal shotgun operators. There was only one officer on the shift who was certified to use the weapon, plus Sgt. Padilla. Therefore, one of the supervisors on the shift had to anticipate switching roles and became tactically engaged in the operation. Fortunately, Sgt. Hull responded to the scene as expected so that there was an available supervisor to take over incident command as the event unfolded.

> RECOMMENDATION 13: The Training Division should evaluate its less lethal shotgun training to ensure that certified officers are all current and familiar with the policies specific to the weapon system.
>
> RECOMMENDATION 14: The Bureau should evaluate whether there is an adequate number of trained less lethal shotgun operators across all shifts and consider training more non-supervisory field officers in the weapon.

Investigation and Review

Five civilian witnesses who observed the shooting were interviewed on the day of the incident by line officers who responded to the scene, then more fully questioned by detectives. The witness observations corroborated the observations

of the involved officers in most relevant areas, including that Harrison ran directly toward police officers in a "threatening manner," yelling and swinging or pointing his arms ahead and that shots were not fired until Harrison was within a few feet of the officers. Most of the civilians noted that Harrison appeared to have an object in his hand but they could not see what it was. One of these witnesses observed that very soon after the shooting, officers started to administer first aid to Harrison.

Harrison was interviewed by detectives while still in the hospital a few days after his surgery. Some of the questions were leading, focused on eliciting from the suspect statements acknowledging that he understood that officers had to use deadly force in order to do their jobs. Because the opinions of the suspect on this matter are irrelevant to either the criminal case or the administrative evaluation of the officers' tactics, this line of questioning seems unnecessary. Mr. Harrison was properly administered Miranda warnings by the Detectives, whose focus was gathering evidence regarding potential criminal charges against him. At some point during that interview, Mr. Harrison invoked his right to speak with an attorney and Detectives appropriately terminated the interview. Ideally, Internal Affairs should have reached out to the attorney to request the opportunity to interview Mr. Harrison separately on issues relevant to the performance of the officers. There was no indication that they attempted to do so.

Sgt. Padilla and Officer McKay were interviewed by Detectives and Internal Affairs investigators three days after the incident. As we have pointed out previously and elsewhere in this report, this delay does not comport with best investigative practices.

The dynamics of the incident changed quickly with Mr. Harrison's rapid movement. Mindful of this, both the Training Division and Internal Affairs investigators focused on the potential danger of crossfire. The Internal Affairs interviewers explored the plausible danger of crossfire in their interviews of involved officers and elicited statements from Officer McKay that she had stopped firing at Mr. Harrison because of the danger her tracking aim might pose to Sgt. Padilla. Training Division recommended that they continue to emphasize instruction to officers to "be aware of cross fire situations" when pointing their guns. Even in an incident where the evidence indicated that officers were aware of the crossfire potential and held themselves in check, this was an appropriate focus on the danger crossfire can pose to officers and the community.

June 28, 2015 ◦ Alan Bellew

On the date of the incident, Officers Michael Currier and Dominic Lovato were working together on routine patrol when they came across two males and a female in an isolated area of a grocery store parking lot standing next to the rear of a vehicle. The officers observed the individuals going through some bags that were on top of the trunk. The officers' suspicion was raised because of where the car had been parked and they decided to engage the persons in conversation to further investigate.[17]

Upon approach, the officers noticed that the bags contained old style cameras. Officer Currier asked for identification. The female subject, who was holding a purse, said she would look for identification as she walked to the car to look inside. Officer Lovato followed her as she entered the car and she threw her purse in the back seat. Lovato then asked for her name and date of birth and told her he could pull up her identification on the computer and verify her identity. She provided the requested information as Lovato walked back to the car to run a computer check. At some point during this encounter, a Police Bureau patrol car came upon the scene containing two officers who asked Officers Lovato and Currier whether they needed assistance. Despite being outnumbered by the three subjects, Officers Lovato and Currier waved the backup away.

Officer Currier, who had been talking to the two males, obtained their names and provided them to Officer Lovato to check on the computer. Officer Lovato confirmed the identity of the female and one of the males. The third subject, who gave the name Alex Bellew, was believed by the officers to have given a false name based on the dissimilar photograph of Alex Bellew that was displayed on the computer.

Officer Lovato walked back and contacted the female who was now seated in the driver's seat of the car. He observed an empty plastic syringe near the bottom of the passenger seat. Lovato also observed an orange syringe plunger cap on the floorboard behind the passenger seat. At that time, Officer Lovato asked for permission to search her car and contents. The female initially denied his request stating there was nothing in the car. Lovato told the female that he had seen the

[17] The precise sequence of events and what each officer observed is inexact in part because both officers profess moving back and forth between the suspect vehicle, the three subjects and their patrol car. The delay in interviewing the officers may also account for the differing recollections of the involved officers.

syringe bag and cap and asked who had been sitting in the passenger seat. The female pointed to Bellew. Officer Lovato then asked the female to step out of the car; she complied and then changed her mind and gave officers permission to search her vehicle. Lovato told the female to stand near the front bumper of their patrol car as he walked toward the passenger side of the car.

Officer Lovato asked Bellew about the presence of the syringe cap and bag in the passenger seat. Bellew told Lovato that he was diabetic. Officer Lovato told him that if he was diabetic that he should have insulin with him and to show it to him. Officer Currier noticed an identification card sticking out of a wallet in Bellew's pocket and grabbed it. The card identified the subject as Alan Bellew. Officer Currier instructed Bellew to sit down in the passenger's seat of the car with his feet outside of the car as he went back to his car to run a computer check on him. When walking back to the patrol car, Officer Currier observed Bellew suddenly stand up and start digging around the passenger door. Currier initially thought that Bellew was trying to acquire illicit drugs that he would then try to swallow. Officer Currier then observed Bellew produce a gun and point it at Officer Lovato.

Meanwhile, Officer Lovato, who was now behind Bellew on the passenger side of the suspect vehicle initially moved towards Bellew when he observed him reaching into the passenger door pocket. Lovato said his intent was to go hands on since he now believed that Bellew was going to attempt to swallow or discard illicit drugs. Officer Lovato then observed Bellew produce a gun and instead ran around the front of the suspect car and fired through the front windshield at Bellew. Officer Currier also fired at Bellew who fell back into the vehicle. After additional officers arrived at the scene, two responding officers and Officer Currier removed Bellew from the vehicle through the driver's side door. A backup officer provided emergency aid to Bellew until paramedics arrived by applying QuikClot, a chemical designed to stem bleeding. Bellew was pronounced deceased at the scene by paramedics.

It was determined that Officer Currier fired four rounds and Officer Lovato fired ten rounds during the incident. The gun observed in Bellew's hand was determined to be a starter pistol.

Timeline of Investigation and Review

6/28/2015	Date of Incident
8/20/2015	Detectives' Investigation completed
8/18/2015	Training Division Review completed
8/10/2015	Internal Affairs Investigation completed
10/11/2015	Commander's Findings completed
11/18/2015	Police Review Board convened

Investigation and Review

Timely Completion

As noted elsewhere, under the current settlement agreement with US Department of Justice, the Police Bureau is mandated to complete all administrative investigations within 180 days. Unlike other cases discussed in this Report, in this case, to the Police Bureau's credit, the time frame for completing the investigation and review of this incident was well within the mandated time frame.

Delay in Interviewing Involved Officers

The involved officers were interviewed by detectives four days after the incident. As we have stated above, this delay in interviewing the officers runs contrary to best investigative practices and leaves the Bureau without any information for days about the shooting incident from those most knowledgeable about the incident. To the credit of the City, as a result of a new collective bargaining agreement ridding the City of the 48-hour rule, Internal Affairs officers can now interview involved officers about their actions and state of mind the date of the incident. We look forward to the time in which we review officer-involved shootings where this preferred investigative practice is finally implemented.

Officers Shown Video Prior to Being Interviewed

At the scene, detectives collected surveillance video of the incident from a nearby business. Prior to being interviewed, the two involved officers requested the opportunity to view any video of the incident. The investigative detectives relayed that request through their chain of command and eventually obtained approval to show the officers the surveillance video prior to interviewing them. When IPR and Internal Affairs learned this had occurred, they objected to the decision, and IPR later wrote a memorandum to the then-Chief of Police expressing concern.[18] The Chief replied by indicating that he had not authorized this procedure, was angry that he had not been included in the decision-making process, and had expressed his displeasure to those that had authorized the preview. According to the Chief, the rationale given for doing so was that the surveillance video did not show anything meaningful. The Chief indicated in his written response that this was beside the point. IPR recommended that the Chief institute policy that would prohibit an officer involved in a shooting from viewing video prior to providing a statement. The Chief declined, indicating that he would decide on a case-by-case basis whether to authorize the previewing of a video by an involved officer.

As we discuss in the Common Issues section of this Report, the Bureau should institute a policy that prevents officers who are involved or witnesses to an officer-involved shooting from being exposed and contaminated from video or audio evidence prior to providing a statement about the incident.

Analysis and Issues Presented

Tactics and Decision Making

Officer Currier said that based on the disheveled appearance and open sores on Mr. Bellew's face, he immediately suspected him to be a heroin user. When the officers saw the individuals around the trunk of the car trying to manipulate the cameras in the bags, they suspected that the cameras might have been stolen. That suspicion was heightened when Officer Lovato observed a syringe bag and cap in the area of the car where Bellew had been seated. The officers' suspicion was

[18] IPR also raised a concern that, contrary to protocols, the Office had not been notified about the shooting until two and a half hours after its occurrence. The Chief indicated that he had instituted additional safeguards to ensure that this unintentional lapse in notification protocols not happen again. We have been informed that since this incident, no additional lapses in notification have occurred.

heightened when Bellew said he did not have identification, gave officers a name, and when they ran the name on their mobile in car computer the photo that came up did not resemble him. Nonetheless, Officers Lovato and Currier rejected the assistance of two fellow Bureau officers who came on scene to offer assistance.

The officers later decided to have another unit respond to the scene so that Bellew could be fingerprinted and his identification definitively ascertained. Officers suspected that Bellew's motive for lying about his identity was to conceal the existence of an outstanding warrant. The officers obtained consent from the female to have the car searched. Officer Currier had already confiscated an identification card he saw sticking out of Bellew's wallet. Officer Currier confronted Bellew about his true name and Bellew admitted he had lied. Bellew was ordered by Currier to sit in the passenger seat so that he could run his name. At this point, officers believed Bellew was a "flight risk." Shortly thereafter, with Officer Lovato close by, Bellew stood up, reached into the side of the passenger door and produced what appeared to be a firearm, resulting in the use of deadly force by officers.[19]

Even as the officers' suspicions about the three subjects grew, particularly as to Bellew, neither officer conducted even a "pat down" search of any of the subjects, or requested them to move to a more secure location. Nor did either officer request backup and, in fact, turned away available assistance when two Bureau officers arrived on scene. The officers said the reason for not conducting a preliminary search was that they did not want to change the encounter from a consensual one to a detention. However, by the time Bellew was ordered to sit in the front passenger seat of the car, the encounter had transformed to a detention. The subjects certainly understood that they were not free to leave at that point, given that the officers had asked and were preparing to search their vehicle, possessed Bellew's identification, and had informed them that other officers were

[19] As a result of the officers talking to the subjects at different times, they learned different things but apparently were not communicating effectively with each other. For example, in his interview, Officer Currier did not relate that Officer Lovato had instructed Bellew to go into the car to find the insulin he said he was taking. Interestingly, the Commander's Memorandum commends the officers for their "unspoken communication." The divergence in knowledge about what the officers learned from the three subjects does not support the Commander's conclusion that they communicated well prior to the incident.

coming to the scene to conduct a fingerprinting of Bellew. And the officers certainly would have stopped Bellew had he tried to flee.[20]

The officers also indicated that they were concerned if they had detained the subjects, it might have resulted in a use of force. Tragically, because the officers did not more closely supervise the movement of the subjects and prevent Bellew from reentering the car, they ended up in a deadly use of force incident. The Terry stop approved by the Supreme Court decades ago[21] was intended to allow officers to engage in tactics that preserved officer safety without offending the Fourth Amendment. In this case, the officers had sufficient articulable suspicion to detain the subjects during the pendency of their investigation. Concurrent with this was the ability to conduct a pat down for weapons and keep the subjects away from the car where officers had already spotted contraband in plain sight. As the male associate, who was one of the threesome, incisively stated during his interview: "I don't know why they ever let him reach back into the car".

Permitting the Subject Access to the Vehicle

Neither the Training Division Review nor the Commander's Memorandum sufficiently addressed the important officer safety issues surrounding the officer's decision to allow Mr. Bellew to return to the car, despite the fact that neither he nor the vehicle had been searched. The Training analysis found that the officers' actions demonstrated sound and effective tactics.

According to the Commander, the Training Sergeant indicated that officers are instructed to order drivers on car stops back into their cars as a manner of controlling the stop. That may be a sound tactic for ordinary traffic stops, where there is no suspicion of the driver other than the observed driving infraction. In this case, Bellew was out of the car when the officers approached. More importantly, when Bellew was ordered back into the car, officers had already seen drug related contraband in plain sight inside the vehicle in the area where they asked him to sit, making it more likely that there was additional contraband inside to which Bellew would now have easier access. These facts, and the distinction

---

[20] The officers articulated as much, indicating that Bellew was ordered into the passenger seat because they believed he presented a "flight risk."

[21] In *Terry v. Ohio*, 392 U.S. 1 (1968), the U.S. Supreme Court found it permissible for officers to briefly detain an individual and absent probable cause to arrest, provided the officers can articulate specific facts that form the basis for a reasonable suspicion that the person has committed a crime.

between a normal traffic stop and this stop, were not sufficiently explored in the Training analysis.

The Commander's Memorandum relied on the Training analysis to find the officers' actions prior to the shooting to be in policy. However, it did identify one area of concern regarding the lack of control of Mr. Bellew prior to the shooting. The Memorandum noted that both officers were clear they attempted to keep the contact low key because they felt they needed more to turn the contact into a stop and wanted to avoid having to use force. The Commander indicated that it was his belief that both officers felt constrained by the current national and political climate regarding the use of force in a relatively low governmental interest charge such as possible drug possession. The Commander recommended the Bureau place a greater emphasis on the officers' rights and ability to use force/control when it becomes necessary to ensure their safety. There is no documentation indicating whether the Bureau followed up on or implemented this recommendation.[22]

Waving Off Backup

With regard to the decision to wave off the unit that had offered to assist, the Training analysis noted that officers were trained that numerical superiority usually increases the chances of success during any encounter. The Training analysis noted that by waving off the on scene help, the officers placed themselves in a tactically inferior position. The Training analysis excused this decision, however, because it concluded that the officers had no indication of any danger at the time they waved the officers away and accepted Officer Lovato's description of the encounter being "innocuous" at that time. It failed to take into account what indicia of illegality the officers possessed at the time they waved their assist away; it is unclear how innocuous the encounter was when they did so. Moreover, the analysis did not appropriately distinguish between deciding not to affirmatively call other units for backup and declining backup assistance that is actually on scene.

> RECOMMENDATION 15: The Bureau should reinforce through training the principle that officer safety should never be compromised when engaged in either consensual encounters or detentions.

[22] In addition, the Commander noted the potential crossfire created as a result of the positioning of the officers but found that the officers remained aware of this potential and acted appropriately.

Fourth Amendment Issues

The Training analysis did not consider whether and if so, when, the encounter between the involved officers and the subjects became a detention. In this case, because the tactical decisions and the reference by the officers to Fourth Amendment concerns are so intertwined, it would have been helpful to have sought the opinion of a Bureau or legal expert on issues surrounding the officers' legal standing to detain or arrest the subject in order to better assess the officers' decision making.

> RECOMMENDATION 16: When issues arise regarding the legality of a stop, search, or detention pursuant to the Fourth Amendment, the Training Division should consult with an expert on these issues prior to completing its review of a critical incident.

Shooting Through Glass

Similar to the recommendation emanating from the Sudlow shooting addressed earlier in this report, the Training analysis recommended that all Bureau members receive training on the ballistic qualities of different types of ammunition and its effectiveness in shooting through different types of glass. There is no documentation regarding whether this recommendation was accepted and/or implemented.

Involved Officer Failed to Update Location

After the shooting incident, officers did not directly respond to the shooting location because Officer Currier, as he candidly admitted, had not updated their location on the Mobile Data Terminal. In two cases discussed in this Report (Swoboda and Bellew), officers involved in shootings made it more difficult for responding officers because they had not transmitted their current location. For purposes of officer safety, it is critical that dispatch and other officers on duty know the location of officers. The Bureau should reinforce this principle at in-service training, and should consider using these two specific critical incidents as examples.[23]

---

[23] The Police Review Board simply recommended that the shooting by Officers Lovato and Currier be found in policy and did not discuss any of the tactical or other decision making of the involved officers as detailed above, even including issues identified by Training and the Commander.

RECOMMENDATION 17: The Bureau should reinforce to its patrol officers the importance of indicating their location and consider using the specific officer-involved shooting incidents as training aids to demonstrate the necessity for doing so.

Post-Incident Actions

Emergency First Aid Given to Injured Subject

In this case, responding officers quickly began life saving measures by using QuikClot in an attempt to stem Mr. Bellew's bleeding prior to the arrival of paramedics. The Commander's Memorandum recommended that the Training Division continue to review the QuikClot product and talk about its use. Training echoed this suggestion and recommended that QuikClot be evaluated by the Tactical Emergency Casualty Care Committee for possible use Bureau-wide. There is no documentation regarding whether there was any follow up or implementation of these recommendations.

RECOMMENDATION 18: When the Commander and/or the Training Division makes a recommendation for systemic change, the case file should document whether the recommendation was accepted and implemented to allow for easier follow up.

Removal of Involved Officers from On-Scene Responsibilities

The reports note that Officer Currier, in particular, played an active role in extracting Bellew from the car and assisting with emergency aid. After the shooting, Officer Lovato kept the remaining male and female subjects secure at gunpoint. When the first level supervisor arrived at the location, to his credit, he timely removed Officers Lovato and Currier from tactical and life-saving responsibilities and replaced them with non-involved responding officers.

Concealing Decedent's Body

After Mr. Bellew was pronounced deceased, a sergeant requested paramedics to place a tarp on him. While the sentiment was well meaning so that Mr. Bellew's body would not be viewable by bystanders, the placement of a foreign object directly on the body has the ability to contaminate the subsequent forensic analysis. To the Bureau's credit, the sergeant candidly indicated that he had been

informed by the responding Detectives that it would not have been their preference to have a tarp placed over the body.

To address this issue, a number of police agencies have deployed body screens in supervisory vehicles. The body screens protect a decedent's body from bystanders yet do not disturb forensic evidence that may be important to the medical examiner.

> RECOMMENDATION 19: The Police Bureau should consider outfitting its supervisory vehicles with body screens to shield the bodies of decedents from view of bystanders during the crime scene investigation.

SECTION TWO

Common Themes and Issues

Review of Tactical Decision Making

Police science and law has increasingly recognized that tactical decision making by officers has significant impact on deadly force incidents. Tactical decisions that keep officers safe reduce the likelihood that those officers will find themselves in a position where they feel constrained to use deadly force. The Bureau has developed admirable tactical training that instructs officers to perform their responsibilities consistent with principles of officer safety. The Bureau has also long recognized the need to assess tactics leading up to the deadly force incident and specially orders a Training Division Review designed to identify tactical decision making and opine whether officer performance was consistent with training and policy.

While the Commander and Police Review Board also often consider some tactical issues leading up to the shooting when evaluating the performance of involved officers, they do so within the structure laid out by Internal Affairs, where the areas of review are generally: "Application of Deadly Force;" "Operational Planning and Supervision;" and "Post Shooting Procedures." Where applicable, there are additional areas of review relating to the use of non-deadly force (such as the K9 or less-lethal shotgun). We frequently see tactical issues – foot pursuits,

vehicle pursuits, or use of the box-in maneuver, for example – discussed under the rubric of "Operational Planning and Supervision," but believe that officer tactics would be more consistently addressed if the Commander and PRB were instructed to consider these issues under a separate area of review – something like, "Pre-Shooting Tactical Decision Making."

Progressive police review boards routinely opine on tactical decision making on every officer-involved shooting, and make a separate finding regarding whether those decisions are in or out of policy. While we have seen cases where the PRB has opined about officer tactics and suggested remediation, it does not consistently make findings about pre-incident tactics, especially decisions made by individual officers. For a full evaluation of the incident consistent with best review practices, both the Commander and the Board should make a finding on the appropriateness of tactics leading up to every shooting they review.

We discussed similar issues of tactics and officer accountability in our Third Report, where we suggested that the Bureau refine its protocols so that the PRB would routinely question whether officers' tactical performance preceding a use of deadly force was so below the agency's expectations that it demands remedial action. We argued that tactical decisions and judgments have consequences that often will determine the need or perceived need to use force and that tactical shortcomings not consistent with principles of officer safety should be appropriately identified and considered as possible grounds for remediation or discipline. We continue to believe the Bureau could improve its review and accountability mechanisms consistent with these principles.

> RECOMMENDATION 20: The Bureau should modify its deliberative protocols so that the review of every officer-involved shooting includes an explicit review of pre-shooting tactical decision making, and express findings from the Commander and Police Review Board on whether officers' tactical performance was consistent with training and policy.

Role of Training Division Review

In order to effectively assess the pre-shooting tactical decision making of involved officers, the Police Review Board needs to continue to consider the Training analysis in its deliberative process.[24] However, we have been informed

[24] In our Third Report, we questioned whether the PRB might rely too heavily on the Training analysis and defer to Training's view of the incident. That concern, however,

that the Bureau intends to modify its review process so that the Training analysis would not be prepared until after the PRB has convened and made its findings regarding an incident. Deprived of the benefit provided by Training's insights on whether the use of deadly force and post-incident conduct was consistent with Bureau expectations, it would be extremely difficult for the PRB to make a determination about pre-shooting officer decision making. We fail to understand the rationale for the decision to delay the preparation of the Training analysis until after the Review Board renders its determination. We urge the Bureau to reconsider and reverse this planned procedural change that would significantly undermine the efficacy of the City's deadly force review process.

> RECOMMENDATION 21: The Bureau should ensure a meaningful review process by continuing to have the Police Review Board review and consider the Training Division Review prior to convening and making a determination.

Video Evidence Procedures

In this report, the question of whether officers involved in deadly force incidents should be permitted to view video of the event prior to being interviewed became an issue in two of the six cases reviewed. In the Bellew case, detectives showed video evidence to the involved officers prior to interviewing them, much to the then-Chief's consternation. In the Sudlow case, Gresham detectives, who were in charge of the criminal investigation because the shooting occurred in their city, allowed the shooting officer to review video prior to being interviewed.

The increasing prevalence of video evidence has raised the stakes in the ongoing debate among police agencies about whether and when an officer involved in a critical incident should be given access to video evidence. Because the goal of investigations into these incidents is to obtain an accurate account of the officers' actions, observations, and state of mind, the better practice is to have the officer provide a statement before viewing any video of the incident. For the same reasons that it is important for officers involved in deadly force incidents to be interviewed shortly after the incident to avoid contamination of recall by extraneous information, it is critical that officers' recollection not be influenced, consciously or subconsciously, by a video or audio account of the incident.

---

was not based on reservations about Training's qualifications, but rather on the observation that PRB members bring their own experience and perspectives to the Board and should not feel restricted to raise only those issues identified by Training.

Exposing the officer to video evidence will influence memory and recall in unpredictable ways. It is accepted practice among law enforcement agencies to separate involved officers from one another after a shooting incident to avoid witness contamination. Watching video of an incident has the similar potential to unnecessarily and detrimentally affect officers' later statements, and agencies should similarly avoid this influence. Instead of the current practice in Portland of relying on the Chief's case-by-case determination, and consistent with IPR's recommendation, it is incumbent on the Police Bureau to develop clear policy that protects the integrity of investigations by insulating officers from having their recall contaminated by video evidence prior to being interviewed. Once a "pure statement" is obtained from an involved officer, the video evidence should be shown to him or her and if that leads the officer to recall additional details or creates a need to clarify the initial statement, the officer should have the chance to provide a supplemental statement or interview.

> RECOMMENDATION 22: The Bureau should develop policy that prohibits officers from viewing video evidence prior to providing an initial statement of their observations, actions, and state of mind following any incident in which they used force or are the subject of an investigation.

Role of On-Scene Sergeants

Our prior reviews of the Bureau's critical incidents have repeatedly included recommendations for training and encouraging sergeants to maintain their supervisory perspective and avoid tactical involvement in incidents in which their officers are involved. The cases we reviewed for this report require us to again emphasize the importance of the sergeant's role on the scene of a critical incident. A sergeant appropriately acting as a supervisor should take command of the incident – directing resources and delegating tactical assignments to officers. The Bureau's training curriculum for supervisors, in its Sergeant's Academy and in Critical Incident Management Class, is consistent with this view.

Nonetheless, in three of the six cases we reviewed for this report, sergeants assumed tactical roles and became directly engaged in the use of force incidents. In the shooting involving Mr. Harrison, Sgt. Padilla was put in a position where he had no choice but to assume a tactical role, as the only certified less-lethal shotgun operator available at the time. Sgt. Padilla demonstrated an awareness that this role was in conflict with his supervisory position, and believed that

another sergeant would respond, but did not explicitly request that response and did not have time to formally relinquish command of the scene. That case demonstrates a concern about Bureau staffing and the numbers of officers who are certified to operate the less-lethal weapons in the Bureau's armory, more than a question of the training, review, or accountability systems relating to the sergeant's role.

In the other two cases, however – Ropp and Sudlow – involved sergeants tactically engaged despite the presence of officers who could have assumed those roles. And in both cases, none of the Bureau's reviewers – Training or Commanders – identified a significant concern over this issue.

We discussed this issue in our second and fourth reports (July 2013 and January 2016), and made the following recommendation in both (RECOMMENDATION 30 and Recommendation 26, respectively). For the sake of clarity, we repeat it verbatim here:

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

In our fourth report, we made an additional recommendation related to this issue (Recommendation 27). We again repeat it here verbatim:

> The Bureau should direct the Training Division to include in its Review of each officer-involved shooting an examination of any supervisory issues presented, with an emphasis on identifying whether first level supervisors engaged tactically instead of assuming a command role.

In response to our last report, the Bureau indicated it agreed with both recommendations and that it was their current practice to comply with both. Nonetheless, following the officer-involved shooting of Mr. Ropp, both the Commander's Memorandum and the Training Division Review simply note that Sgt. Holbrook was the lead car in the vehicle pursuit, while finding the pursuit to be in policy and consistent with training. At the terminus of the pursuit, Sgt. Holbrook was positioned to be the officer responsible for detaining the remaining

suspects at gunpoint while other officers pursued Mr. Ropp on foot. Again, the reviewers identified no concerns about Sgt. Holbrook's role.

The failure to identify the issue or impose any accountability measures here is particularly striking given the fact that Sgt. Holbrook was engaged in an officer-involved shooting more than two and a half years before this incident that we reviewed in our Fourth Report. While his use of deadly force in that case was found to be within policy, the Training analysis found his tactical engagement in that scenario to be inconsistent with training, given the presence of numerous officers who could have stepped into his role while he maintained a supervisory presence. It is not clear why his similar decision to engage tactically in this incident was not the subject of anyone's concern.

Likewise, in the shooting involving Mr. Sudlow, Sgt. Duilio assigned himself to be the driver of the second car tasked with performing the box-in maneuver, despite the fact that he was the supervisor in charge of the custody team. Both the Training analysis and the Commander's Memorandum in that case identified significant concerns with the incident supervision because of the way involved sergeants managed the planning around the shift change and the decision making around the authorization of the box-in. It is conceivable that the issue of Sgt. Duilio's tactical engagement got lost among these seemingly bigger issues, but if so, that perhaps highlights the fact that the Bureau is not paying sufficient attention to concerns about sergeants' tactical roles.

The fact that sergeants continue to engage tactically in incidents where they could and should instead maintain a supervisory role makes us question the effectiveness of training on this point. Because the curriculum itself is thorough and on point, we question the degree to which Bureau members have "bought into" the training. The very best training can be meaningless if officers don't believe in its importance or validity, either because of the way it is delivered or because of preconceived notions of their role as police officers. For that reason, it is critical that an agency's review and accountability mechanisms reinforce training concepts, to ensure that officers receive the message that the agency's leaders believe in the importance of what is being taught. When the Bureau neglects to acknowledge sergeants' failures to delegate non-supervisory tasks, it undermines training about the management of critical incidents.

Indeed, the outcomes of these two cases cause us to question the Bureau's prior assertions that training, review, and accountability mechanisms sufficiently address this issue. An important way for a law enforcement agency to reinforce training directives that have been seemingly ineffective on their own at changing

behavior or performance is to develop policy to address the issue. This serves two functions – it sends a strong message to the agency's members about the importance of the directive, and makes it easier to hold members accountable who are apparently not getting the message. Because the issue of sergeants assuming tactical roles has been an ongoing concern throughout the years we have reviewed Police Bureau critical incidents, we offer the following recommendation.

> RECOMMENDATION 23: The Bureau should develop specific policy that instructs sergeants on the need to maintain their supervisory perspective and avoid tactical involvement in incidents when officers are available to perform those roles and should hold supervisors accountable for violating those directives.

Rendering Emergency Aid to Injured Subjects

As part of the Bureau's review process, the Internal Affairs investigation, the Training Division Review, the Commander's Memorandum, and the Police Review Board have all increased emphasis on reviewing the post-shooting actions of responding personnel. Particular focus is on how first aid is rendered to injured individuals. For example, increased emphasis has been placed in the investigative phase to identify and interview responding emergency personnel regarding their actions and observations. In addition, each reviewing entity (Training, Commander, Police Review Board) is instructed to opine or make recommended findings with regard to post-incident activity, including the rendering of medical aid. This enlargement in focus is consistent with best investigative and review practices for officer-involved shootings and a testament to the robust review mechanism that the Bureau has created.

The speed with which officers provide medical care to individuals injured in an officer-involved shooting has been a topic of discussion in nearly all of our prior reports, beginning in 2012. In that first report, we examined the 2010 shooting of Aaron Campbell, which had motivated the Bureau to finally address the issue by equipping all sergeants' cars with ballistic shields. These shields can provide officers cover and defense when they approach an injured suspect who may still have a weapon or may become aggressive. In our last report, two of the cases we reviewed caused us to question the efficacy of the training provided to sergeants and officers on the use of the ballistic shields, and recommended that the Bureau

review its training to confirm that it accurately instructs on the capabilities and limitations of the shield.

In the current report, we discussed the issue of delayed medical attention in two of the officer-involved shootings reviewed. Viewed as a group, four of the six cases examined in this report involved subjects who were struck by police gunfire and remained at the scene. In two cases – those involving Mr. Bellew and Mr. Harrison – the subjects were handcuffed almost immediately, checked for weapons, and then given emergency medical aid. The other two cases – those involving Mr. McClendon and Mr. Swoboda – by contrast, had significant time gaps between the officer-involved shooting and the rendering of any medical attention.

Significantly, in both those incidents, subjects McClendon and Swoboda exhibited very different states of consciousness. Mr. McClendon was awake, moving on the ground, yelling and taunting the officers and refusing to follow orders to move away from the gun near his arm. The captain who took control of the scene decided not to allow the arrest team to move in despite the availability of ballistic shields, called SERT and waited another hour for them to arrive, handcuff the subject and begin to administer medical aid.

Subject Swoboda, conversely, said nothing, did not move, and appeared to be unconscious or dead. He was, nevertheless still viewed as a potential threat because the gun he had used to shoot Officer Romero lay nearby. The supervisor organized an arrest team from available officers at the scene, had them deploy ballistic shields and retreat to safety as soon as they had approached and handcuffed the subject. Even after handcuffing, the officers did not render emergency aid and instructed paramedics to limit their response due to their apparently overarching concern about disturbing evidence.

We are mindful that these judgment calls are not simple ones. A supervisor must weigh the potential threat still posed by the subject to the officers and the community against the imperative for law enforcement officers to preserve human life, even if the subject has just attacked officers.

Factors like the presence of a weapon, the statements of the subject, the nature of the subject's injuries, the availability of a ballistic shield and/or hard cover for the officers, whether civilians in the area could be endangered by any aggression from the subject or defensive actions by the officers come into play but may remain very difficult to quantify. It is encouraging that after three of the four

shootings where the officers had the injured subject in sight, supervisors consciously weighed the factors and made a decision.

In their analysis of the McClendon shooting, the Training Division suggested that in future cases, SERT should automatically be deployed immediately after a shooting where the subject is not in custody. On its face, this seems like a prudent idea, but we are concerned that an automatic SERT deployment would encourage the Bureau to go backwards to the time prior to the Aaron Campbell shooting in 2010, when it was not unusual for it to take officers 30 minutes or more to reach injured subjects with emergency medical care because they routinely waited for SERT, regardless of the level of threat posed by the subject. In any event, in Mr. McClendon's case, automatic SERT deployment would only have saved 10 or 12 minutes of the ultimate 70-minute delay.

We instead recommend that ballistic shields be more widely available and that their use be more widely trained among patrol officers. A ballistic shield does not resolve every officer safety concern, but in some circumstances, it can provide just enough protection to officers to tip the balance between security concerns and medical aid concerns. Unfortunately, medical attention was slow to Mr. Swoboda despite the availability and effective use of the ballistic shield allowing a safe handcuffing and neutralization of any threat. In the McClendon incident, the shield was deemed insufficient to resolve the potential threat posed by the subject who remained unsecured, active, verbally aggressive and close to his gun.

> RECOMMENDATION 24: The Police Bureau should assess the use of the ballistic shield to determine whether additional attention to the distribution and training of this tool could reduce the delay time between injuries to subjects and the rendering of emergency aid, including the need to render medical attention immediately after any potential threat has been effectively neutralized.

Timeliness of Investigations

The settlement agreement between the City of Portland and the Department of Justice, while negotiated over many months, was not finalized and accepted by the federal judge until late August 2014, when two of the incidents discussed in this report had already been under investigation and review for months. The settlement agreement established, among other things, a 180-day time limit for the Bureau to complete all internal investigations and review processes following an officer-involved shooting. The Bureau has complied with this commitment in three out of the six cases we reviewed and in two out of the four cases commenced after the implementation of the settlement agreement.[25]

In most cases, Internal Affairs is not a bottleneck. For most of these cases, the initial internal affairs investigation was complete within 60 days of the incident. Two cases took Internal Affairs another week or two.

Internal Affairs in fact tries to comply with the Bureau's internal guideline of 42 days to complete their investigation so as not to hold back the rest of the process. Each of the two cases with significant overruns (more than four months tardy), however, involved additional investigation requested of Internal Affairs by a Bureau executive, plus consequent revisions of the Internal Affairs report. The reasons for these requested additional investigations were well documented. Extending an investigation and revising reports are by themselves signs of a healthy review by Bureau decision makers. Each time this occurred, however, the Internal Affairs unit appeared to lose its productive rhythm. Performing the additional investigative tasks and report revision took five and seven extra months, respectively, for each of the two cases.

We do not suggest that additional investigations or appropriate expansion and revision is a bad thing. Quite the contrary; conducting additional fact finding is often necessary to produce an internal investigative product that meets the Bureau's standards. We appreciate the challenge of asking an investigator, already pressed to meet a 42-day deadline on existing cases, to take on extra work on a case he or she thought was complete. But, if requesting additional interviews causes the progress of a shooting investigation to go into a five or more month detour, this could discourage executive reviewers from making such requests in the future. This may in turn create pressure for executives to settle for what they

[25] Included as an Appendix is a table depicting the time for investigation and review of all cases we have examined since 2010. We have printed this table in past reports, and add the six incidents reviewed in this report to the version we include here.

recognize as a flawed or incomplete investigation. For that reason, we suggest that Internal Affairs find a way to give priority to requests for further investigation and fulfill those in a timely manner.

One other way in which the Bureau can try to avoid undue delays is to attempt to convene Police Review Boards more swiftly. The PRB meetings occurred at least two months after most case investigations were completed and in half the cases three or four months later. While there are many persons in and out of the Bureau who participate in a PRB proceeding and whose time and schedules must be respected, one to two months' notice seems adequate to the task.

> RECOMMENDATION 25: The Bureau should fashion a way for Internal Affairs to expedite additional investigation and report revisions when requested with regard to any officer-involved shooting. The Bureau should identify obstacles to timely completion of such additional investigation and provide extra resources if necessary.
>
> RECOMMENDATION 26: The Bureau should convene PRB proceedings within two months of the completion of the Internal Affairs report in officer-involved shootings and inform the relevant Commander of the need to complete his or her findings in time to comply with this deadline.

SECTION THREE Recommendations

1 The Police Bureau should modify its notification protocols so that a supervisor within the subject officer's chain of command is assigned to meet with the employee and communicate the disposition of any sustained internal investigation.

2 The Police Bureau should develop a mechanism whereby a tactical debrief is scheduled with all officers involved in deadly force incidents, including any insights documented in the Training Division Review and the Commander's Memorandum. The occurrence of the briefing should be documented and included in the officer-involved shooting investigative file.

3 The Police Bureau should advise its use of deadly force instructors to instruct officers that the basis for using deadly force should focus on the imminent danger presented by the subject's actions to them or identifiable third parties rather than speculative unidentified victims who may be in the vicinity.

4 When an officer uses profanity in engaging a subject, the Training Division Review should identify it and opine upon its appropriateness.

5 The Bureau should continue to train its field sergeants on the need to render or coordinate first aid as soon as possible and should not instruct paramedics to downsize its response team in the interest of not disturbing evidence.

6 The Training Division should reconsider its recommendation on tourniquet training based on case-by-case differences, and should ensure that medical professionals are consulted regarding the circumstances under which the application of a tourniquet is advisable.

7 The Police Bureau should devise protocols assigning on scene supervisors the responsibility of identifying any property loss or damage as a result of police actions in critical incidents.

8 The Police Bureau should work with the City to devise a methodology to proactively reimburse any uninvolved persons who have suffered property loss or damage as a result of police actions in critical incidents.

9 Investigators should not request or permit attorneys who accompany their clients on a walk through to offer “evidence” about the incident.

10 The Police Bureau should consider following up in this case and cases of this nature where an arrestee has recently been put on a 72-hour hold through the intervention of law enforcement. Some investigation into the circumstances of the medical authorities’ decision to release the subject early could provide valuable insight into the advisability of that decision and the Bureau could develop a diplomatic and constructive method to provide medical authorities and Project Respond with this potentially valuable feedback.

11 When a Commander makes a finding that an employee’s performance is out of policy, the Police Review Board should be required to expressly state any reasons for its own finding that diverges from the Commander’s view.

12 The Bureau should develop a process for review and evaluation of situations in which the analysis of a critical incident generates significant disagreement among members of the Training Division as to whether an officer’s actions were consistent with training.

13 The Training Division should evaluate its less lethal shotgun training to ensure that certified officers are all current and familiar with the policies specific to the weapon system.

14 The Bureau should evaluate whether there is an adequate number of trained less lethal shotgun operators across all shifts and consider training more non-supervisory field officers in the weapon.

15 The Bureau should reinforce through training the principle that officer safety should never be compromised when engaged in either consensual encounters or detentions.

16 When issues arise regarding the legality of a stop, search, or detention pursuant to the Fourth Amendment, the Training Division should consult with an expert on these issues prior to completing its review of a critical incident.

17 The Bureau should reinforce to its patrol officers the importance of indicating their location and consider using the specific officer-involved shooting incidents as training aids to demonstrate the necessity for doing so.

18 When the Commander and/or the Training Division makes a recommendation for systemic change, the case file should document whether the recommendation was accepted and implemented to allow for easier follow up.

19 The Police Bureau should consider outfitting its supervisory vehicles with body screens to shield the bodies of decedents from view of bystanders during the crime scene investigation.

20 The Bureau should modify its deliberative protocols so that the review of every officer-involved shooting includes an explicit review of pre-shooting tactical decision making, and express findings from the Commander and Police Review Board on whether officers' tactical performance was consistent with training and policy.

21 The Bureau should ensure a meaningful review process by continuing to have the Police Review Board review and consider the Training Division Review prior to convening and making a determination.

22 The Bureau should develop policy that prohibits officers from viewing video evidence prior to providing an initial statement of their observations, actions, and state of mind following any incident in which they used force or are the subject of an investigation.

23 The Bureau should develop specific policy that instructs sergeants on the need to maintain their supervisory perspective and avoid tactical involvement in incidents when officers are available to perform those roles and should hold supervisors accountable for violating those directives.

24 The Police Bureau should assess the use of the ballistic shield to determine whether additional attention to the distribution and training of this tool could reduce the delay time between injuries to subjects and the rendering of emergency aid, including the need to render medical attention immediately after any potential threat has been effectively neutralized.

25 The Bureau should fashion a way for Internal Affairs to expedite additional investigation and report revisions when requested with regard to any officer-involved shooting. The Bureau should identify obstacles to timely completion of such additional investigation and provide extra resources if necessary.

26 The Bureau should convene PRB proceedings within two months of the completion of the Internal Affairs report in officer-involved shootings and inform the relevant Commander of the need to complete his or her findings in time to comply with this deadline.

Appendix: Timing to Completion of Investigation and Review

Subject's Name	Date of Incident	Time to Review Board*
Bellew	6/28/2015	143 days
Harrison	5/17/2015	116 days
Sudlow	2/17/2015	321 days
McClendon	9/1/2014	163 days
Ropp	4/16/2014	327 days
Swoboda	3/12/2014	196 days
Cisneros	3/4/2013	6 months
Hatch	2/17/2013	6 months
Baker	9/29/2012	8 months
Tate	8/21/2012	9 months
Simms	7/28/2012	9 months
Blackmon	7/17/2012	10 months
Potter	3/26/2012	11 months
Morgan	1/25/2012	14 months
Johnson	7/10/2011	13 months
Monroe	6/30/2011	16 months**
Turner	3/6/2011	21 months
Higginbotham	1/2/2011	12 months
Moffett	1/1/2011	22 months
Lagozzino	12/27/2010	15 months

Subject's Name	Date of Incident	Time to Review Board
Ferguson	12/17/2010	13 months
Boehler	11/23/2010	19 months
Otis	5/12/2010	16 months
Collins	3/22/2010	14 months
Campbell	1/29/2010	7 months
Lovaina-Bermudez	8/24/2008	8 months
Coady	5/15/2008	13 months
Spoor	5/13/2008	17 months
Turpin	10/5/2007	15 months
Stewart	8/20/2007	15 months
Bolen	5/22/2007	16 months
Carter	12/28/2006	14 months
Hughes	11/12/2006	23 months
Suran	8/28/2006	20 months
Goins	7/19/2006	12 months
Grant	3/20/2006	16 months
Young	1/4/2006	13 months
Gwerder	11/4/2005	18 months
Vaida	10/12/2005	13 months
Perez	3/28/2004	8 months

*Cases covered in this report are shaded. Time for these cases is expressed in days, following the format for DOJ prescribed timelines.

** In Monroe, it took another 11 months before Officer Reister was notified of the Bureau's intent to terminate him, officially ending the administrative process.