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

Fourth Report • January 2016

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Foreword

This is OIR Group's fourth report on Portland Police Bureau's officer-involved shootings and in-custody deaths. It is our fifth report to the City of Portland, counting our July 2010 Report concerning the death of James Chasse. In all, the Portland City Auditor has tasked OIR Group with reviewing 32 officer involved shootings and three in-custody deaths involving the Portland Police Bureau that occurred from March 2004 to March 2013. This report, our final under our current contractual relationship with the City, reviews 11 officer-involved shootings that occurred over a span of two years and three months, from January 2011 to March 2013.

To provide a recap of the 35 critical incidents we have reviewed, we prepared a table (found in the Appendix to this report) listing and providing some basic facts about each. As laid out in the table, subjects died in 19 of the 32 officer involved shootings. Eighteen of the 32 subjects at whom officers fired had a history of mental health issues or were experiencing some type of mental health crisis. Nine shootings involved African-American subjects; three involved Latinos; and 20 involved white subjects.

While it is useful to see this information compiled in a table and to critically examine the numbers and trends, our reviews also focus on the many details of an event that cannot neatly be encapsulated on a chart or described by a set of data. We delve deeply into each critical incident, to examine each decision that the officers made, their level of planning and communication with each other, willingness to consider alternative plans, and the effectiveness of on-scene supervisors to manage and direct resources and control the scene.

The Bureau's internal processes for investigating and reviewing these incidents is equally important to the conduct of the officers in the individual incidents, and therefore given equal weight in our analysis. As we have written repeatedly over the years, the Bureau is superior to most comparable law enforcement agencies in the way in which it reviews critical incidents. There is, however, always room for improvement. This is true at the individual case level, but also systemically. Throughout this report, we make recommendations for the further evolution of the Bureau's internal review standards, to meet and address both the expectations of Portland's engaged citizenry and the national reconsideration of effective policing and legitimate use of deadly force.

Increasingly, the public has raised its expectations for officer performance, and extended its scrutiny beyond the baseline questions of legality and officer perception at the moment of trigger pull to the tactical considerations that come into play before the decision to shoot. When officers use tactics consistent with principles of officer safety – taking time to slow down their response, when feasible; maintaining distance between themselves and subjects; and remaining in positions of cover when possible – they are less likely to be in a position where a use of deadly force becomes necessary. The Bureau's existing review process, if properly implemented, is ideal for evaluating these tactical decisions that impact the outcome of the incident. However, the Bureau's remaining work comes in ensuring that the implementation of this review process is consistently at the optimal level for all incidents and that the results of the review are used to make appropriate changes to policy, training, and equipment.

Systemically, an important foundation is in place. In the span of the 35 incidents we have reviewed, the Police Bureau has made significant strides in its willingness to acknowledge the reality of tactical deficiencies, even in the context of a legally justified shooting. For example, as we discuss below, the shooting death of Brad Morgan in 2012 provides evidence of a Bureau willing to learn and grow from its mistakes. Similarly, the Bureau has also shown improvement in the

speed with which officers secure injured subjects so that medical personnel can safely enter the scene to treat them, an issue that has been the source of critique in numerous prior incidents.

We remain concerned, however, about the length of time it takes to interview an involved officer following a shooting. Since our first report, we have advocated for the removal of the "48-hour rule" from the City's contracts with the police unions that requires the Bureau to give 48 hours advance notice prior to a compelled administrative interview. While there has been some recent progress with the Portland Police Commanding Officers' Association agreeing to a rescission of the rule, the overwhelming majority of officers involved in shootings are not members of this union, so the change does little to affect the Bureau's inability to obtain contemporaneous officer interviews after a critical incident. We hope the union representing line officers will follow the lead of its sister association and work with the City on this issue during the next round of contract negotiations.

Of the cases we review in this report, the most striking common feature is that in seven of the 11 incidents, there is some evidence that the subject had the intent to precipitate a deadly force encounter with police with the desire to end his own life. We discuss that phenomenon in detail in the Common Issues section of this report, and find that in some of these cases, during its review, the Bureau was too quick to assume that the subject's state of mind and subsequent actions "forced" officers to use deadly force. In these reviews, the Bureau was less open to evaluating the possibility of alternative approaches to the scenario that might have afforded officers a better opportunity to influence the outcome. We caution the Bureau against adopting the language, culture, and mentality that suggests the death of a suicidal individual who appears intent on provoking a confrontation with police is always inevitable.

We have consistently reported on the Bureau's complete and objective investigations, and that perception endures across these latest cases. Where we have noted deficiencies, as we do in this report, we have found the Bureau open to those critiques. We also have observed the Bureau's willingness to be self-critical in its review process, to confront perceived deficiencies, and to do so in an open and transparent way. The City's agreement with the U.S. Department of Justice following that agency's review has opened the Police Bureau to a new level of scrutiny and commitment to reform. As a result of that agreement, the Bureau is showing significant improvement in the length of time it takes to complete its

internal investigations and reviews, but we caution the Bureau not to sacrifice thoroughness for the sake of timeliness.

The role of the Auditor's Independent Police Review Division also has evolved since its inception in 2001. The office initially had little to say about the Police Bureau's investigation and review of critical incidents. Now, however, in addition to the role the office plays with respect to citizen complaints, a member of the office rolls out to the scene of an officer-involved shooting, meets regularly with Internal Affairs investigators to discuss the timing and scope of the investigation, sometimes sits in on interviews of witnesses and involved officers, approves the Internal Affairs investigation for quality and thoroughness, approves the initial findings, and is a voting member on the Police Review Board. As noted below, the office also weighs in on requests for delays in the investigative and review process. This increased role for the City's civilian oversight body is evidence of the City's commitment to having the Police Bureau produce complete, objective, and transparent investigations into shootings and other critical incidents.

We have been reviewing critical incidents for the City of Portland for six years, through the span of three different Chiefs of Police, and while we criticize some parts of the process and find some inconsistencies with individual reviews, one thing has been consistently noteworthy: the level of cooperation we have received from the Police Bureau's executive team. In addition to providing assistance as we gathered all relevant documents, training, policies, and practices, Bureau representatives have been uniformly generous with their time, candid and helpful in answering our questions and responding to our concerns. That degree of receptivity to our work is not universal among the agencies with whom we have worked, and we thank the Bureau for its consistent willingness to engage. While we will not always agree about interpretation of the facts or the best ways to reduce the likelihood of officer involved shootings, the dialogue and interest in listening to each other allows us to think harder about our recommendations and hopefully causes the Bureau leadership to continue to evaluate their position as well.

Scope of Review

As we have done for our prior reports,[1] we reviewed all of the Bureau's investigative materials for each of the 11 critical incidents, including the Detectives' and Internal Affairs' investigations, as well as grand jury transcripts where available. We also read and considered the Training Division Review and materials documenting the Bureau's internal review and decision making process connected with each incident. We requested, received, and reviewed relevant training materials, referred back to training materials we reviewed for our prior reports, and interviewed current Training Division personnel. We also talked with Bureau executives regarding questions that were not answered in the initial materials provided and requested additional documents that were responsive to those questions.

Our analysis centers on the quality and thoroughness of the Bureau's internal investigation and review of each of the incidents presented. We look at relevant training and policy issues, and corrective actions initiated by the Bureau. We do not opine on whether any particular shooting, or related tactic or use of force, is within policy, but do point out where we see conduct contrary to what we understand is expected. We do fault the Bureau, however, when we find 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.

As with our previous reports, this report contains three sections after this Foreword. Section One contains a factual summary of each of the 11 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. We also have included an Appendix detailing all 35 cases we have reviewed in this and prior reports.

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[1] Our prior reports include the following:
Report Concerning the In-Custody Death of James Chasse, July 2010;
Report on Portland Police Bureau Officer Involved Shootings, First Report, May 2012;
Report on Portland Police Bureau Officer-Involved Shootings, Second Report, July 2013;
Report on Portland Police Bureau Officer-Involved Shootings, Third Report, November 2014.

SECTION ONE

Officer-Involved Shootings

Summary and Analysis

January 1, 2011 ◦ Kevin Moffett

On the date of the incident, a Portland Police Bureau officer was flagged down regarding a disturbance at a nightclub. As he waited for cover officers to arrive, he heard a series of gunshots. The officer broadcast this information and then Sergeant Michael Fort[2] self-dispatched himself to the scene. When he arrived, he exited his vehicle.

Shortly thereafter, the first officer heard additional gunshots and at the same time, Sergeant Fort observed an individual, later identified as Kevin Moffett, standing on the sidewalk and firing a handgun at a group of people. Sergeant Fort, who was standing in the street, discharged his handgun one time in the direction of Mr. Moffett. The bullet missed Moffett and struck a brick wall of a parking structure. Sergeant Fort then followed Moffett on foot as the suspect fled on foot. Other responding Portland Police Bureau officers eventually took Mr. Moffett into custody in a nearby park.

[2] Sergeant Fort was promoted to lieutenant while the investigation was pending, yet the investigative and review materials refer to him as Sergeant Fort, which we also will do in the remainder of this report.

Mr. Moffett's gunfire had fatally wounded a security guard who worked at the nightclub. Mr. Moffett was charged by a grand jury with the killing and eventually pleaded guilty to the homicide.

The District Attorney determined that Sergeant Fort's use of deadly force was not to be presented to a grand jury and negotiated with him to provide a non-recorded statement to the grand jury that was hearing potential charges against Mr. Moffett. The Bureau found that Sergeant Fort's use of deadly force was within policy.

Timeline of Investigation and Review

1/1/2011	Date of Incident
1/10/2012	Internal Affairs Investigation completed
5/3/2012	Training Division Review completed
6/25/2012	Commander's Findings completed
10/30/12	Police Review Board convened

Analysis/Issues Presented

Tactical Decision Making

The Training Division Review found that a number of Sergeant Fort's tactical decisions were consistent with principles of officer safety and Bureau training. Those included making effective use of parked vehicles as cover and concealment when he approached the shooting location, firing only one round to stop the suspect, following the suspect using principles of distance and concealment, and broadcasting the suspect's location of travel as the suspect ran from him.

However, the Training analysis also found several tactical decisions made by the Sergeant that were not ideal. First, the analysis noted that when Sergeant Fort arrived at the location, even though he observed the first responding officer seated in his police car and on the radio, he did not contact him to coordinate resources or gather information but instead proceeded alone toward the crowd from which

the shots had emanated. As a result, the Review found that Sergeant Fort did not have a "cover officer" nor did he obtain any additional information about the incident.[3] The analysis determined that Sergeant Fort put himself at risk by these actions – he was out in the open, in the immediate area of an unknown gunman who had yet to be located or identified.[4] The analysis concluded that Sergeant Fort's actions were not consistent with Bureau training and that he had other options that would have made his response more consistent with principles of officer safety.

The Training Review further noted that after Sergeant Fort fired the one round, he did not broadcast that fact nor did he request that medical respond and stage for the security guard who had been shot. The analysis concluded that these actions were similarly not consistent with Bureau training.

Despite the Training Division's findings, the Acting Captain responsible for making recommendations to the Review Board regarding the tactics of Sergeant Fort concluded that he performed "extraordinarily well" and attributed any actions of the sergeant that might have been subpar to the "fog of war." While acknowledging the Training Division Review found the sergeant had not in several respects performed consistent with training, the Acting Captain excused his actions, concluding that the "immediacy" of the situation did not fit with a typical police response and that the incident was "immediate, ongoing, and chaotic." The Acting Captain determined that there were times that Bureau members needed to place themselves at increased risk and that this incident was one of those times. Contrary to the Training Division's conclusion that Sergeant Fort's failure to broadcast that he had used deadly force was inconsistent with training, the Acting Captain concluded that the sergeant had made notification at the "appropriate" time. Curiously, even though the Acting Captain concluded that Sergeant Fort had performed "extraordinarily well," he recommended that the incident be debriefed by others focusing on issues such as planning and effectively communicating. In other words, while the Acting Captain believed that the Bureau should continue to receive training on these important tactical concepts, he recommended no remediation for the involved individual who had performed inconsistently with them.

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[3] The initial responding officer reported that he was not even aware that Sergeant Fort had been present at the location or that he had fired his weapon at the suspect.

[4] To his credit, in his interview Sergeant Fort admitted that he was not in a good position of cover at the time he used deadly force.

The Training Division had access to the same investigative materials as did the Acting Captain, but found no cause to conclude that it is acceptable for members to perform inconsistently with their training when a situation is "immediate, ongoing, and chaotic." Nor did the Training Division indicate that it trained Bureau members to sometimes place themselves at "increased risk" in order to fulfill their public safety responsibilities. In fact, police trainers have indicated to us that it is precisely the "chaotic" times when it is most important to follow principles of officer safety so that members do not place themselves at increased risk and compound the potential for even more disastrous results. Most importantly, the Acting Captain failed to acknowledge the Training Division's conclusion that under the "chaotic" conditions presented, Sergeant Fort had other tactical options by which he could have effectively responded to the threat.

Quality of Investigation and Review

Delay in Obtaining Involved Officer's Statement

On the date of the incident, Sergeant Fort declined to be interviewed by detectives about his use of deadly force.[5] Sergeant Fort provided two non-recorded statements to detectives but those statements were focused on the actions of Mr. Moffett with respect to the homicide for which he eventually was convicted. Sergeant Fort also provided a non-recorded statement to the grand jury that was investigating the actions of Mr. Moffett. The Bureau did not obtain the involved officer's account of his use of deadly force until more than 48 hours after the incident, when Internal Affairs investigators interviewed Sergeant Fort. As we have discussed repeatedly in past reports and elsewhere in this one, the failure of the Bureau to obtain a statement from an officer regarding his use of deadly force until two days after the incident is inconsistent with best investigative standards. It is imperative that law enforcement agencies obtain an account on the date of the incident as to why one of its officers decided to use deadly force. This incident was one of the first in a series of cases in which Bureau officers stopped

[5] Interestingly, on the date of the incident, one responding Bureau officer reported that he observed Sergeant Fort sitting in a police car with a Bureau lieutenant and that after the lieutenant walked away, "it seemed like" Sergeant Fort wanted to talk about the incident and began to talk about certain observations he had made of the subject's actions. However, the reporting officer advised Sergeant Fort that unless the incident presented a "safety issue," Sergeant Fort should not discuss the incident "a whole lot" until the Association provided him with an attorney. By the time detectives made a request for a formal interview, Sergeant Fort had consulted with his attorney and advised the detectives he would not provide a statement.

providing voluntary statements to detectives on the date of the incident. While the Bureau continues to work on protocols designed to ensure its officers provide a more timely account of any use of deadly force, until it is able to return to a situation where officers give that account on the date of the incident, the Bureau's officer-involved shooting investigations are not completely consistent with progressive investigative principles.

Inordinate Delay in the Investigation and Review Process

As noted above, this incident took almost two years for the Bureau to investigate and review. While this case suffered from some of the regular delays we have reported on in the past, there was an even greater potential for delay in this case when the District Attorney requested that the administrative review be postponed until the criminal case against Mr. Moffett was completed. To its credit, the Auditor's Independent Police Review Division objected to this additional delay and the then Chief of Police decided to proceed with the review despite the District Attorney's objection. The decision by the Chief not to delay the review was the correct call. The timing of internal reviews should not be impacted by whether a criminal case against the person shot has been completed.

Surveillance Video of Shooting

The question of when to show a video of an event to officers involved in deadly force incidents is a subject of great current interest. Best investigative practices dictate that in order to obtain a pure statement of the officer's state of mind and his or her own memory, it is imperative that officers provide a statement prior to watching the video. In this case, consistent with those practices, investigators showed Sergeant Fort a recording of the nightclub shooting, but only after they obtained a statement from him about his observations and recall.

January 2, 2011 ◦ Thomas Higginbotham

On the date of the incident, a private security guard called 911 and reported that an individual, later identified as Thomas Higginbotham, had threatened her and attempted to assault her, was refusing to leave the commercial property to which she was assigned, and was possibly armed with a knife. An East Precinct officer was first dispatched to the call. Officers Jason Lile and Larry Wingfield radioed that they would assist.

Officer Wingfield arrived at the commercial property first, and spoke briefly with the security guard. She told him that the subject had threatened her, she had ordered him off the property and that she wanted him arrested for trespass. By the time that officers had responded to the property, Mr. Higginbotham had walked away. The security guard said she believed that the man was living at an adjacent abandoned car wash. The officer who had been initially dispatched to the call arrived at the location and stayed with the security officer to talk with her further while Officers Lile and Wingfield proceeded to the car wash.

Upon arrival at the car wash, the officers observed a man inside the building who provided them access to the structure. The man told the officers that the owner of the building had given him and Mr. Higginbotham permission to live in the structure. The man directed the officers to an inner room where Higginbotham was staying. The officers approached, knocked, and told Mr. Higginbotham through a closed door that they needed him to come out so that they could talk with him. Higginbotham told the officers that he had a knife.

Eventually, Mr. Higginbotham came out of the room holding a knife. Officer Lile fired his Taser at him but it had no apparent effect. Officers later learned the Taser probes had not penetrated the heavy clothing that Mr. Higginbotham was wearing to make contact with him. According to the officers, Mr. Higginbotham continued to advance upon them and, in fear for their lives, Officer Wingfield fired eight rounds and Officer Lile fired four rounds. Mr. Higginbotham was struck by ten of the rounds fired. Officers quickly called for medical assistance to respond but rescue was briefly staged nearby until Mr. Higginbotham could be separated from the knife and dragged from the close quarters where he had gone down to a more open area so that paramedics had sufficient space to work. Attempts to resuscitate proved unsuccessful and Mr. Higginbotham was pronounced dead at the scene.

The grand jury found no criminal liability with regard to the deadly force deployed by Officers Wingfield and Lile and the Bureau found their actions within policy.

Timeline of Investigation and Review

1/2/2011	Date of Incident
1/20/2011	Grand Jury concluded
4/9/2011	Internal Affairs Investigation completed
10/4/2011	Training Division Review received*
11/11/2011	Commander's Findings completed
1/18/2012	Police Review Board convened

*The Training Review is undated but the copy provided to us was stamped "received" on October 4, 2011. We recommend that Training Division Reviews be dated so that the completion date can be readily ascertained.

Analysis/Issues Presented

Tactical Planning and Decision Making

The officers here made some questionable tactical decisions before obtaining all relevant and available information. The Training Division Review and Commander's Review and Findings noted some, but not all, of these issues.

- ***Insufficient Fact Gathering***

The Training Division Review found a number of decisions by the officers that were inconsistent with Bureau training. First, the analysis noted that when the officers first arrived at the commercial establishment, they did not take sufficient time to gather information regarding the details of the incident with the security guard and relevant information about the suspect's potential for volatile behavior. The Review indicated that more time spent with the security guard may have revealed further details, particularly since there was information in the radio

broadcast communicated to the officers that the suspect was potentially armed with a knife and had displayed assaultive and threatening behavior to the security guard.

The Review observed that while Officer Wingfield had knowledge of much of this information at the conclusion of his brief interview with the security guard, only rudimentary facts were relayed to Officer Lile, who had inexplicably remained in his patrol car when Officer Wingfield was talking with the security guard. The Training analysis concluded that the information was critical and should have been the focus of the officers' preliminary investigation because it may have impacted their response. The analysis found that the officers' initial investigation appeared to be rushed, resulting in a lack of total situational awareness.

The analysis noted that Bureau officers are trained that the more information that they can gather prior to an encounter, the more time they have to assess the level of the threat and plan a response. Training opined that the failure to gather relevant and available information here led to confusion regarding the officers' legal standing when confronting the suspect. The Review concluded that the insufficient fact gathering conducted by the involved officers was inconsistent with Bureau training.

The Commander's Review and Findings acknowledged that while the security guard had alerted the officers that Higginbotham had been seen with knives in the past, she had not seen one produced during the incident for which she had called. While the memorandum concedes that Officers Wingfield and Lile communicated only minimally about their plan and that there could have been more clarity about each officer's actions and responsibilities as the incident unfolded, both the Commander's Review and Findings and the Training Review concluded that there was nothing suggesting that a formal planning session would have changed the results, as the incident was "driven by Higginbotham's actions" after contact.

While both the Commander's Review and Findings and Training Review point out several problems with regard to the involved officers' failures to sufficiently gather some information before confronting Mr. Higginbotham, both documents failed to note other key pieces of information that the officers neglected to ask about. Specifically, officers could have learned more about the location, status, and likelihood that Mr. Higginbotham was armed, most significantly in their discussion with the transient who provided them access to the car wash. Instead of asking that individual in advance whether Higginbotham possessed weapons

and using that information to gauge how or even whether to approach the room in which he was located, the officers asked him only after they first knocked on the door and began to engage with Mr. Higginbotham.

- ***Simultaneous Deployment of Taser and Handgun***

The Commander's Review and Findings notes that the potential use of the Taser was not discussed by the involved officers nor was there a plan formulated about who would use the Taser if less lethal force was needed. The memorandum concludes that these issues should have been discussed prior to attempting to contact the suspect. It further notes that having a plan ahead of time offers clarity when chaos ensues.

The memorandum also recounts that Officer Lile deployed the Taser in his left hand while he held his handgun in his right hand. He explained that while he uses a right handed holster for his gun, he is actually left handed and decided to use his left hand to deploy the Taser as he thought he may have to subsequently use lethal force and did not want to put his handgun away. While the Commander acknowledges the Bureau does not teach this technique to its officers, the memorandum notes the "philosophy and concept" is acceptable and the tactic is reasonable, as officers are taught to transition from weapon system to weapon system during an encounter. The Training analysis did not identify Officer Lile's simultaneous deployment of the firearm and the Taser as an issue.

There is, however, no basis for the conclusion that the "philosophy and concept" is acceptable. It would have been helpful to the Bureau's review of this incident to learn why the Training Division does not train to have a Taser in one hand and a firearm in another at the same time. While the Commander found this technique reasonable, there are reasons why the tactic is not trained, such as the concern that an officer under stress will mistakenly deploy lethal when the officer intended to deploy less lethal, or vice versa.

More pertinent to this case, if the officers had devised a plan ahead of their tactical approach and determined who would deploy less lethal, Officer Wingfield could have been the lethal cover officer, negating Officer's Lile's perceived need to have both his gun and Taser simultaneously unholstered. In a broader sense, if there was a concern that one officer was going to need to transition from less lethal to lethal, the two officers could have waited for the third officer to arrive and used the additional resource and options a third officer on scene could have provided.

- ***Decision to Approach and Engage Subject***

Another issue not discussed by either the Training Review or the Commander's Review and Findings is whether it was consistent with principles of officer safety for the officers to approach Mr. Higginbotham's room and attempt to engage him. Officer Wingfield testified before the grand jury that the hall leading to Mr. Higginbotham's room was a "dark" and "scary looking place." He further testified that their experience in the car wash was a "kind of barricade." Officer Wingfield told Internal Affairs that in order to get to Mr. Higginbotham's room, they had to travel down a narrow path, with bad lighting, and no place to acquire cover. Officer Wingfield further said that "stuff" was packed two feet high on either side of the narrow path. Officer Lile told Internal Affairs that he, Officer Wingfield, and the civilian walked like "three ducks in a row"[6] because there was nowhere to go other than the path due to the clutter in the building.

Given the many physical challenges presented by the approach to Mr. Higginbotham's room, if the officers would have gathered the available information suggesting Mr. Higginbotham was likely armed, the officers could reasonably have determined that it was unsafe for them to make contact with him the way in which they did. They may have instead decided to hail him from a farther and safer distance, and if he refused to come out, may have declared the situation a barricade and requested activation of the Special Emergency Reaction Team (SERT). Had the situation unfolded in this way, the outcome likely would have been different.

The involved officers themselves recognized the perilous situation in which they had placed themselves. Officer Wingfield indicated that they had found themselves in a "bad spot to be in," that he was "caught on the wrong side of the room," and acknowledged that they had let the suspect get way too close. Officer Wingfield said that once Higginbotham came out of the room with the knife he tried to back up but kept tripping on clutter. Officer Wingfield told the grand jury that because they were not able to make it out the door, the only remaining option was to shoot the suspect.

[6] The transient only walked the officers to the door and then officers ordered him to back away into the bay of the car wash, which he did.

- ***Allowing Subject to Drive Outcome***

Perhaps most concerning in the officers' statements and the Bureau's analysis is their concession that the suspect dictated the outcome of this incident. Officer Wingfield testified that when Higginbotham came out of the room and advanced on the officers with a knife, he began to come to the realization that the suspect was going to "make us shoot him." The Training analysis concluded that the incident was largely "driven" by the aggressive reaction of Mr. Higginbotham. The Commander's Review and Findings concurred that the incident was "driven" by Higginbotham's actions after contact.

As we have stated before, tactical decision making that is consistent with principles of officer safety provides smart techniques for detention and apprehension that provide police the ability to more frequently influence how the encounter will end. In many cases, the tools, training, resources, and abilities of police officers can and should be employed so that an incident will culminate on the police officer's terms. For a police agency to conclude that it was unable to change an outcome despite the tactical advantages it has surrenders too much control and gives too much credit to suspects. Particularly here, where Mr. Higginbotham was found holed up in a room, was not going anywhere, and did not present a threat to anyone else, time and resources were on the side of the officers. The Bureau did not consider whether the suspect was able to "drive" the outcome because the officers failed to equip themselves with critical information about the suspect that they could have readily obtained, failed to devise and communicate to each other a plan on how to deal with him, and performed inconsistently with principles of officer safety by positioning themselves too close to him with no opportunity for cover or tactical repositioning, so that he was then able to "force" the officers to use deadly force on him.

In our Second Report, we similarly commented on verbiage in a supervisory analysis that suggested the suspect was in control of the outcome and "dictated" the officer's use of deadly force. While sometimes the use of deadly force will be unavoidable, it should be the goal of the Bureau's experts to provide training and guidance to its members so those circumstances are held to a minimum. In cases where a smarter and more cautious response could have affected the outcome, the suspect's intent notwithstanding, the Bureau should instill in its command staff the will to identify those cases and critique officer conduct and decision making accordingly. For that reason, we repeat here a recommendation from our Second Report.

Recommendation 1: The Bureau should ensure that command staff recognizes that it should be the overarching objective of every tactical engagement for the Bureau to influence the outcome.

The "21-Foot Rule"

When he appeared before the grand jury, Officer Wingfield testified, "They train us to not let anybody get within 21 feet of you with an edged weapon." The origin of this "21-foot rule" was a Salt Lake City police officer who performed a rudimentary series of tests and concluded that an armed attacker who bolted toward an officer could clear 21 feet in the time it took most officers to draw, aim, and fire their weapon. In 1988, Calibre Press produced a training video entitled "Surviving Edged Weapons" that repeated the 21 foot conclusion and was widely distributed to police agencies. In a May 2015 conference sponsored by the Police Executive Research Forum (PERF), police chiefs in attendance said that unfortunately the "21-foot rule" has been taught informally in police academies and in some cases it has morphed into an incorrect way of thinking.[7] The chiefs were concerned that instead of seeing the 21-foot rule as a general warning to think defensively and protect themselves when confronted by a person with a knife, some officers came to see the rule as a legal justification to shoot a person with a knife who is less than 21 feet away. Chiefs were further concerned that the rule has been cited to justify the use of deadly force in incidents when other tactics might have allowed a resolution of the situation without deadly force.

The chiefs at the PERF conference concluded that the 21-foot rule should never be seen as a green light to use deadly force or as creating a "kill zone." Rather, officers should be given broader training in sound decision making, de-escalation strategies, and tactics for creating time and distance so they can better manage the incident without needing to resort to force.

In a 2009 follow up report, the Police Assessment Resource Center found that the Portland Police Bureau was still training its officers on the 21-foot rule and found that the rule had been misapplied in at least two training analyses. PARC recommended then that the Bureau should clarify the 21-foot rule, emphasizing

[7] The discussions at the PERF conference with regard to the 21-foot rule and other contemporary use of force issues was incorporated in a document that PERF subsequently produced and made publicly available entitled: "Re-Engineering Training on Police Use of Force."

that it does not per se justify any shooting when the suspect is less than 21 feet away.

The testimony presented by Officer Wingfield at the grand jury is evidence that the lore of the 21-foot rule may still be inculcated in the Portland Police Bureau. Some officers may have reached the simplistic and mistaken conclusions as feared by the chiefs at the PERF conference. For that reason, it is incumbent upon the Bureau to provide its officers more contemporary training that updates its expectations when officers are confronted with edged weapons instead of the simplistic messages that could be wrongly exported from a video made over 25 years ago.

Recommendation 2: The Bureau should ensure that its officers have not misinterpreted the principles behind the 21-foot rule and provide more contemporary training designed to ensure that officers recognize the appropriate considerations in determining whether and when to use deadly force against someone wielding an edged weapon.

Post-Incident Response

After the shooting, the involved officers took positions of cover. Officer Wingfield notified dispatch that shots had been fired and requested medical to respond Code 3 to the location. With other officers providing cover, the officer who had been originally dispatched to the trespass call and who had arrived at the car wash shortly after the incident, retrieved the knife from Higginbotham's hand and gave it to a sergeant, who had arrived on scene and assumed the role of incident commander.

When paramedics arrived on scene, the original plan was to hit Higginbotham with a bean bag in order to determine his condition. However, because of the close quarters in which Higginbotham had fallen, the sergeant asked an officer to kick the suspect in the legs to see if there was any movement. Upon observing no movement, the sergeant decided to have officers move Higginbotham from the confined space into an area where rescue personnel could have sufficient space to treat him. As officers began dragging Higginbotham to a less confined area, the sergeant then grabbed Higginbotham's arm and pulled him into the car wash bay, where paramedics began attending to him.

Another responding sergeant reported that when he encountered paramedics as he was arriving at the location, they informed him they did not know where to stage.

Early in the post-incident response, the sergeant instructed officers to clear the car wash building to determine if there were other individuals located in the structure. Prior to detectives' arrival on scene to commence their investigation, the sergeant determined that a more thorough clearing of the car wash structure was required to locate any possible additional transients who might be in the building. As a result, according to his report, he contacted the supervisory detective who had yet to arrive, obtained assent to conduct another sweep, and assigned himself, two additional on-scene sergeants, and an officer to clear the building.

The Training Division and the Area Commander opined that the post-incident response was reasonable and consistent with training.

- ***Field Supervisor's Tactical Involvement***

While, as noted above, the Training Division Review and the Commander's Review and Findings praised certain decisions made by the incident field sergeant, neither document discussed his significant tactical involvement in the post-shooting response. For example, the officer who retrieved Mr. Higginbotham's knife gave it to the sergeant to secure. Then, rather than supervise the movement of Higginbotham to the car wash bay, the sergeant participated in the process himself. Finally, when he determined it was necessary to clear the building again, he assigned himself and two supervisors to do so rather than delegate the responsibility to officers.

Bureau protocols and training instruct supervisors to assign tactical responsibilities to officers while they supervise and manage the operation. While the sergeant did assign certain tasks to officers, as noted above, he assigned himself to perform other tasks that officers could have completed under his supervision. This level of personal tactical engagement may provide a partial explanation for why the sergeant did not apparently think to assign an officer to meet emergency personnel when they arrived on scene and direct them where to stage. In any event, the Bureau post-incident analysis should have examined the sergeant's response more critically to reinforce the principle that supervisors are expected to command, not perform.

Quality of Investigation and Review

Timeliness of Review Process

The investigation and review of this shooting took over a year to complete. The longest delay was for completion of the Training Division Review, a period of almost six months. The Bureau must create internal mechanisms designed to ensure a prompt preparation of that analysis so that other participants in the review process are able to perform their functions in a timely.

Delay in Obtaining Accounts of Incident From Involved Officer

When asked on the date of the incident to provide a voluntary statement to detectives, Officer Lile refused to provide one and Officer Wingfield indicated that he would do so if the statement were non-recorded. It is unclear from the investigative report whether Officer Wingfield in fact provided a non-recorded statement to detectives.[8] Three days later Internal Affairs interviewed the officers – the first time the Bureau obtained the officers' account of the shooting incident.[9]

We have written repeatedly about the problems created by the Bureau's inability to obtain statements from involved officers any earlier than 48 hours after a critical incident. The procedural history in this case is yet another example of the importance of obtaining a contemporaneous account of a deadly force incident. The failure to do so was particularly problematic here, given the absence of any uninvolved witness officers. This fact was acknowledged by the Bureau Commander in his Memorandum in which he stated that the refusal of officers to provide an interview to detectives had created a "void" in the investigation that could adversely impact officers in future incidents. In order to restore community confidence in these investigations, the Bureau must return to a situation where they obtain such an account from its officers on the date of the incident.

Failure to Include Bulletin Regarding Transients at the Car Wash

Officer Lile reported that on the date of the incident he had read a bulletin issued by the Police Bureau regarding transients frequenting an abandoned car wash.

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[8] Obtaining non-recorded statements from officers involved in shootings would violate standard Bureau protocols.

[9] One of the detectives assigned to the investigation wrote that the first briefing he obtained of the incident came from an attorney representing one of the shooting officers who had talked to the officer and then relayed the officer's account to the detective.

The bulletin could have provided helpful information regarding Officer Lile's state of mind and knowledge of the issue had it been retrieved and incorporated into the investigative file. However, there is no further reference in the investigation to any subsequent efforts to retrieve the bulletin referenced by the officer.

Fourth Amendment Issues

As noted above, when Officers Wingfield and Lile arrived at the abandoned car wash, they encountered an individual who said he had permission from the owners to stay there. He then opened the structure and allowed the officers to enter. Upon further inquiry, the individual informed the officers that Mr. Higginbotham stayed in a room in the building and directed them to it. Appropriately, when detectives arrived to take over the shooting investigation, they contacted the owners telephonically and received verbal consent to search the premises.

The officers' entry onto the premises implicates potential Fourth Amendment issues. Questions arise about whether the individual first contacted by the officers had the authority to allow the officers entrance into the car wash and/or whether the circumstances presented to the officers provided them legal authority to enter the structure regardless of whether the individual gave them consent. For purposes of this discussion, it is irrelevant whether the officers did or did not have the Constitutional authority to enter the car wash building. This incident squarely presented that legal question, and the Bureau's reviewers should have addressed it. While there is a one-line observation in the Training analysis about the officers' legal standing, there was no detailed analysis of the issue. Because the circumstances of an officer-involved shooting are among the most consequential events within the Bureau, it is incumbent upon the Bureau to consider, discuss, and fully evaluate all Constitutional and other issues that arise, even if they are tangential to the actual use of deadly force.

Recommendation 3: When the circumstances surrounding an officer-involved shooting present Constitutional issues regarding the decision making of involved officers, the Bureau's review process should incorporate, discuss, and assess those decisions.

June 30, 2011 ◦ William Kyle Monroe

On the date of the incident, the Police Bureau received a 911 call reporting that an individual, later identified as William Monroe, was bothering children in a park. Later, another caller reported that the individual was armed with a knife. Three Portland officers responded to the incident, including Officer Dane Reister. According to Officer Reister, when he located the individual in the park, he attempted to detain him by using verbal commands but the subject did not follow his instructions.

Officer Reister then obtained a less lethal shotgun from his police car and continued his efforts to have Mr. Monroe comply with his instructions to get on the ground. According to Officer Reister, Mr. Monroe disregarded his commands and began to run. Officer Reister then discharged the less lethal shotgun four times, striking Mr. Monroe in the lower torso and legs. When Officer Reister and two other responding officers secured Mr. Monroe, they observed he was bleeding profusely. After further assessment at the scene, the officers saw shotgun shell casings and realized that the weapon had been improperly loaded with lethal shotgun rounds instead of the less lethal beanbag rounds specifically designed to be loaded into a less lethal shotgun.[10] Mr. Monroe was handcuffed, treated by paramedics at the scene and transported to the hospital. The shotgun rounds fractured Mr. Monroe's pelvis, and pellets penetrated his bladder, abdomen, and colon, resulting in significant permanent injuries. Investigators later learned that Mr. Monroe had a history of mental illness.

When he realized that Officer Reister had discharged lethal rounds at Mr. Monroe, an on scene sergeant began preserving the crime scene and making notifications consistent with deadly force investigation protocols.

Subsequent to a criminal investigation conducted by the Police Bureau, on November 18, 2011, Officer Reister was indicted by the grand jury on Third and Fourth Degree Assault charges. Subsequently, the District Attorney's Office added a charge of Negligent Wounding. In July 2012, the judge assigned to the criminal case dismissed the Negligent Wounding charge and the District Attorney appealed. In the spring of 2013, the City settled a lawsuit brought on Mr.

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[10] As explained in more detail below, the Portland Police Bureau equips its certified officers with both lethal and non-lethal shotguns. The non-lethal shotgun platform is easily distinguishable from the lethal shotgun because of its distinctive color. However, the current weapon system used by the Bureau allows lethal and less lethal ammunition to be used interchangeably in both the lethal and non-lethal shotgun platforms.

Monroe's behalf for $2.3 million. On October 2, 2013, the Bureau notified Officer Reister of its intent to terminate him for his actions. While the criminal appeal remained pending, the untimely death of Officer Reister ended any further proceedings.

Timeline of Investigation and Review

6/30/2011	Date of Incident
11/18/2011	Grand Jury indicted Officer Reister
5/3/2012	Internal Affairs Investigation completed
7/12 2012	Training Division Review completed
9/5/2012	Commander's Findings completed
11/7/2012	Police Review Board convened

Analysis/Issues Presented

Sufficiency of the Termination Letter

The Chief of Police's letter informing Officer Reister of the Bureau's decision to terminate him primarily faults him for his mistake in loading lethal ammunition into a non-lethal weapon system. In addition, however, the letter faults Reister for his failure to recognize after he fired his first round that he was firing lethal rounds. According to the letter, there is a distinct and noticeable difference in how the two types of rounds feel and sound when they are fired. The letter further indicated that unlike a deadly force situation, this was not an incident in which there was an immediate threat of harm since Mr. Monroe was running away and therefore Officer Reister was not facing a deadly threat when he deployed.

The Training Division Review of this incident concluded that it would "hope" that Officer Reister would have been able to "immediately realize that he was not firing a less lethal round after the first shot," but "it was not possible to expect an officer in this situation to recognize the audible and physical feedback from a

firearm." The Training analysis further stated that this type of recognition could not be addressed through training.

While the Chief of Police should not be bound by conclusions reached by the Training Division, when a Chief's decision conflicts with Training's findings, the Chief should clearly acknowledge the contrary position and state the rationale behind the disagreement. To not do so explicitly will increase the likelihood that any appeal from the discipline will be significantly undermined by the unaddressed findings from the Bureau's training experts.

Recommendation 4: When the Chief's disciplinary determination is based on a rationale that contradicts conclusions made in either the Training Division Review or the Commander's Review and Findings, the disciplinary letter should explicitly address the contradiction and set out the reasons for the disagreement.

Systemic Remediation in Response to the Incident

During the extensive criminal and administrative investigations of this case, the investigators spent significant time interviewing Officer Reister in an attempt to discern how he ended up deploying a less lethal weapon loaded with lethal rounds. Unfortunately, no clear answers emerged on precisely how the situation unfolded or when the lethal rounds were inserted into the less lethal weapon. Regardless, the Bureau appropriately determined that Officer Reister bore the fundamental responsibility for the tragic error. The investigation also exposed a lack of clarity about whether Officer Reister had been properly certified to even use the less lethal weapon.[11]

The Training Review also spent considerable time reporting on systemic changes that the Police Bureau had made as a result of the incident, and made recommendations for additional reform. The analysis noted that based on an immediate recommendation by the Training Division, the Bureau issued an Executive Order prohibiting non-supervisory Bureau members to possess additional or replacement less lethal munitions. The Executive Order further required that less lethal shotguns be stored in the armory with less lethal rounds

[11] Officer Reister asserted that while he did not actually attend a less lethal certification class, his attendance at another class provided him the requisite certification. The investigation revealed that shared belief among other attendees and even some instructors. In any event, Officer Reister ended up regularly deploying less lethal munitions for several years as a result of this confusion.

stored in a side saddle carrier and/or butt stock carrier. The Order further required operators to visually inspect each round as they load and encouraged (but not required) them to have another Bureau member view and confirm the loading process. Finally, the Order required that all less lethal ammunition be carried in its original factory packaging.

With regard to the certification confusion, the Training Division immediately notified officers that had not attended a specific less lethal certification course they were not considered certified to carry a less lethal shotgun until they had attended the specific certification course. Other additional recommendations were made by Training in order to shore up identified deficits in the certification and training materials retention processes.

The Training Division also recommended that because of the "versatility, durability, cost, ease of use and training of the 12 gauge shotgun," the Bureau should continue to use the shotgun as the delivery platform for the less lethal rounds. Training encouraged continued investigation into other options as they became available for use on the law enforcement market and recognized that best practices are always evolving.

The Bureau should be commended for moving quickly to identify some ways to reduce the likelihood of any similar future confusion and for enacting the Executive Order to implement those changes. Moreover, as a result of legal proceedings stemming from this incident, outside experts provided additional recommendations for systemic reform. The Multnomah County District Attorney retained a police practices expert to assist with the evaluation and prosecution of the case against Officer Reister. The expert examined numerous documents and reports, visited the Bureau garage, locker room and armory, and consulted with Training Division staff.

While the expert opined that the Bureau's Executive Order referenced above was a "step in the right direction" and noted progress in documenting the less lethal training and qualification of officers, he also opined that additional appropriate measures should be considered to reduce any future likelihood of officers being similarly confused about ammunition. Those included:

- Removal of the 12 gauge less lethal shotgun platform from the Bureau to be replaced with a platform non-interchangeable with the lethal shotgun.
- Assignment of less lethal platforms to specific less lethal officers rather than being stored in the armory to be checked out.

- The practice of loading and unloading should not be performed inside a patrol vehicle but only at a safe ballistic containment area.
- The lighting conditions in the patrol unit parking areas where officers often loaded and unloaded less lethal weapons should be improved.
- Each officer should have an assigned locker for the storage of the officer's patrol bag so that the bags would no longer be left lying around unsecured.
- Less lethal platforms and lethal platforms should not be stored together in a patrol armory.
- In order to prevent sympathetic fire from on scene officers armed with lethal weapons, officers should be trained to make an announcement just prior to less lethal deployment such as "bean bag" or "less lethal."

Officer Reister's criminal defense attorney also retained a police practices expert. In a Declaration filed in Court, the expert found that the process by which Police Bureau officers check out and load their weapons was poorly designed and allowed for the mistake in the shooting of Mr. Monroe to occur. The expert similarly commented on the poor lighting of the police garage where Officer Reister's duty bag had been stored and where he may have loaded the lethal munitions into the less lethal shotgun.

The expert further noted that Bureau officers did not all have assigned lockers for their duty bags and generally stored them on metal racks in an unsecured parking garage. The expert opined that any individual walking off the street into the garage could get to these bags and take ammunition, police safety equipment and personal items, and found that there were no human controls present to monitor the police units nor did the parking structure have video surveillance.

Perhaps most importantly, the expert noted that the Bureau could completely remove the risk associated with comingling lethal ammunition with less lethal specialty munitions by transitioning from the shotgun platform to a non-shotgun shooting platform. According to the expert, he had been informed that prior to the date of the shooting of Mr. Monroe, the Bureau's command staff had received a recommendation that they transition to a less lethal launching system incompatible with the shotgun and that the launchers were offered to the Bureau without cost if the Bureau would agree to purchase the reusable less lethal sponge round munitions for the system.

The Police Review Board[12] similarly recommended unanimously that the Bureau look into having two distinct platforms for less lethal and lethal shotgun weapon systems, so that the ammunition rounds would not be interchangeable.

While the Bureau has informed us that it adopted many of the recommendations advanced by the outside experts, it is still considering whether to move to a weapons deployment system that would make the insertion of lethal rounds into a less lethal weapon impossible. We urge the Bureau to implement this recommendation.

Recommendation 5: The Bureau should implement the recommendation made by the Police Review Board and outside experts following the shooting of Mr. Monroe and move to incompatible lethal and non-lethal weapons platforms.

Efficient and Effective Post-Incident Response

After it was discovered that Mr. Monroe had been shot with lethal shotgun rounds, the on-scene sergeant adeptly transitioned to handling the incident as an officer-involved shooting. He separated Officer Reister from the immediate location, placed him with a chaperone officer and instructed on-scene officers not to disturb evidence and to cordon off the crime scene with evidence tape. He also made the necessary notifications and requested further resources. An off-duty lieutenant also arrived and offered his experience to ensure that Bureau protocols for officer-involved shootings were followed. Most importantly, on-scene officers recognized that Mr. Monroe did not pose a threat and expressly requested emergency responders to "step up" their response, communicating with them that

[12] The Police Review Board was created in 2010, replacing what had been known as the Use of Force Review Board and the Performance Review Board. It serves as an advisory board to the Chief of Police, reviewing internal investigations into alleged misconduct, making findings and proposing discipline or other corrective action. It is made up of five voting members, including the subject officer's Assistant Chief and Commander, the Independent Police Review Director, a peer member who is the same rank as the subject, and one community member. It also includes nine advisory members, including a facilitator, coordinator, the remaining Assistant Chiefs, and representatives from the Police Commissioner's office, Professional Standards Division, Training Division, the Bureau of Human Resources, and City Attorney's Office.

they did not need to stage[13] but could respond immediately to the crime scene, ensuring that medical assistance was provided to Mr. Monroe as soon as possible.

Bureau Response to Prior Policy Violation

Officer Reister's termination letter refers to an earlier incident in which he received a letter of reprimand for unsatisfactory performance as a result of his failure to unload a weapon prior to a training exercise and then firing a smoke projectile resulting in the injury of another officer. However, while Officer Reister admitted that he made a mistake and viewed the incident as a learning experience, there was apparently no formal retraining provided to Officer Reister as part of the Bureau's remedial action. Moreover, the incident did not result in a sufficiently robust review of Officer Reister's training records to identify that he had not taken the less lethal certification class yet was regularly deploying less lethal munitions in his duty assignments.

Recommendation 6: In addition to any discipline imposed, the Bureau should include a targeted retraining component whenever it determines that a member has violated its performance policy.

Tactical Issue Not Identified or Addressed

Officer Reister indicated that at one point he did not fire his less lethal shotgun because a fellow officer had moved into his line of fire. This issue was not identified during the Training Review. If the evidence did establish that the tactical response of other officers unnecessarily compromised Officer Reister's response, the issue should have been identified and addressed in the Training analysis and, at a minimum, discussed with the responsible officer who had moved into Officer Reister's line of fire.

Quality of Investigation and Review

Significant Delay in Obtaining the Involved Officer's Statement

On the date of the incident, detectives requested that Officer Reister provide a statement but he declined. It was one week before Officer Reister provided a

[13] Sometimes, rescue units are requested to "stage", which means that they respond to a designated location near the crime scene until on-scene Bureau personnel determine whether the situation is sufficiently safe to allow paramedics to enter and provide emergency medical treatment.

voluntary statement; a delay far too long for effective fact gathering and inconsistent with best investigative practices.

Inclusion of Medical Records in Investigative Report

In earlier reports, we have taken the Bureau to task for its failure to include medical records of persons injured by gunfire in its investigative reports. We were encouraged here, however, to see that the extensive medical records of Mr. Monroe were obtained and included as part of the investigation.

Failure to Obtain Tape-Recorded Statements of Civilian Eyewitnesses

Internal Affairs investigators discovered two civilian eyewitnesses to the incident that had not provided recorded statements to detectives during the criminal investigation. To the investigators' credit, they completed the fact gathering by obtaining recorded statements from these witnesses but by then several months had passed, making recollection for these witnesses more problematic. We have generally been impressed by the quality and thoroughness of Detectives' investigations. Here, an after action review to determine why detectives did not identify these witnesses could have provided valuable lessons to the Detective Division.

Failure to Include Forensic Report in Investigative File

The Internal Affairs investigative log references a test fire conducted by the Oregon State Police with regard to this incident to assist in determining how far Officer Reister was from Mr. Monroe when he fired the four lethal rounds. According to the log, the test concluded that the final round was fired from 15 feet away. However, the OSP report is not included in the investigative file. Investigators should have obtained a copy of the report and included it with its investigation. If the report was not available, they should have documented their efforts to obtain it.

Delay in Investigative and Review Process

As noted above, the length of time from the incident to the Review Board was 17 months, too long a period of time for investigating and reviewing officer-involved shootings. Even more concerning, it took almost another year following the Review Board hearing before Officer Reister received a termination letter. This delay apparently was tied to the length of the criminal proceedings. While, to its

credit, the Bureau eventually decided to issue the termination letter before the extenuated criminal proceedings had concluded, it should have made that determination within a reasonable time after the Review Board had issued its recommendations to the Chief.

January 25, 2012 ◦ Brad Lee Morgan

Shortly after 3:00 a.m. on January 25, 2012, Brad Morgan called 911 and reported that he had robbed someone at knifepoint in downtown Portland and currently was standing on top of a 10-story building planning to commit suicide. He would not reveal his exact location, but dispatch was able to track the call to a general area and assigned Central Precinct officers to respond. While officers worked to identify and search possible locations, the 911 call taker kept Mr. Morgan on the line, engaging with him about the source of his suicidal feelings. During the course of that nearly 20 minute conversation, the dispatcher seemed to build a good rapport with Mr. Morgan.

While she was talking with Mr. Morgan, the dispatcher was simultaneously relaying information to officers about the content of their conversation, including clues he revealed about his location, his clothing and appearance, and that he possibly had a gun and, according to the dispatcher, was "making suicide by police statements." The audio recording of the call shows these statements to contain more detail that was not passed on to officers on scene. Specifically, Mr. Morgan said, "I'd actually prefer for a police officer to shoot me at this point. I, I'm not looking forward to this jump." He also said, "I want to take one of their lives," and, later, "I'm not gonna hurt myself. I'm gonna provoke the police to do it or I'm gonna jump off after that doesn't work."

When officers located Mr. Morgan standing on top of the elevator structure on the top floor of a 10-story parking garage at SW 3rd Avenue and SW Morrison Street, Morgan and the 911 call taker ended their conversation so Morgan could begin to talk to the officers.

Officer David Michael Scott, along with several other officers, was dispatched to the call involving Mr. Morgan. Sergeant John Holbrook also responded to the call, and was the primary sergeant in charge. It was as officers were coordinating their activities to try to locate Mr. Morgan that the dispatcher relayed information about him possibly having a gun and "making suicide by police statements." At that point, a different sergeant (who was monitoring but not assigned to the call) got on the air to advise officers to wait for backup before resuming their searches of various structures in the area. Officer Scott was at that point almost to the top of the structure where Mr. Morgan eventually was found, but stopped and backed down to a lower level to wait for a cover officer to join him. When another officer and his trainee caught up, they drove in tandem to the top floor of the parking structure where they eventually located Mr. Morgan standing atop a

concrete structure housing the elevator at the southwest corner. Sergeant Holbrook arrived shortly after.

Sergeant Holbrook and Officer Scott moved away from their patrol cars to try to get close enough to talk to Mr. Morgan while maintaining distance and cover, but found they could not hear what Mr. Morgan was saying and likewise did not believe he could hear them. They made the decision to leave their position of cover to approach Mr. Morgan in order to facilitate a face-to-face conversation and hopefully convince him not to jump. They moved to about 40 feet away, behind a short concrete barrier that provided minimal cover, particularly given that Mr. Morgan's perch was elevated approximately five to six feet. Officer Scott took the lead in talking with Mr. Morgan, and felt like he was establishing a positive connection. Sergeant Holbrook maintained command of the scene, and was coordinating radio traffic and the response and position of other officers while also monitoring the conversation with Mr. Morgan. He assigned an AR-15 rifle operator to assume the role of long cover, and brought a third officer up to be a part of the communication team. When Mr. Morgan believed he recognized that officer and objected to talking with him, Holbrook directed him to return to the patrol cars and have another officer approach. After a short time, that officer decided to return to his patrol car to get his jacket, so Holbrook and Scott were the only two officers engaging with Mr. Morgan in a consistent way. After several minutes of talking with Mr. Morgan with no substantial progress, Sergeant Holbrook requested that both Project Respond[14] and the Crisis Negotiation Team[15] respond to the scene.

Officer Scott engaged with Mr. Morgan about the difficulties in his personal life that were motivating his suicidal thoughts and attempted to offer him some

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[14] Project Respond is a mobile mental-health crisis response team that provides round-the-clock crisis intervention and mental health emergency services in Multnomah County. They work closely with Bureau officers, but will not get involved in a situation that is not secure. Had Project Respond personnel arrived on scene, they would have staged in a secure location away from the top floor of the parking structure and would not have gotten involved to evaluate or offer assistance to Mr. Morgan until officers had de-escalated the situation.

[15] The Crisis Negotiation Team (CNT) has 26 members, but all of them work in other assignments and are not employed full-time as negotiators. There is no CNT component on duty 24 hours a day, so when they are called out to a scene, negotiators either come from their home if off-duty, or from another assignment. If CNT members had arrived at the scene before the shooting, they would have taken over communications with Mr. Morgan.

encouragement for how things might improve if he would let the officers get him help. At some point, though, the conversation deteriorated. Mr. Morgan asked, "What would happen if I pulled a gun out right now?" While both Scott and Holbrook tried to personalize a response about why he would not want to do that, he then said something about how he could kill one of them and how it does not count if he killed a cop. Shortly after he made these statements, Mr. Morgan walked toward the front of the ledge, closing the distance between him and the officers to about 15 feet, put his hand in his pocket or waistband and pulled out what appeared to be a black semiautomatic pistol. Sergeant Holbrook and Officer Scott – both of whom had purposefully kept their guns holstered up until this point in an attempt to avoid escalating the situation – drew their weapons. Sergeant Holbrook fired three rounds from his 9mm handgun, all of which apparently missed. Officer Scott attempted to fire, but his 9mm gun malfunctioned. He cleared the jam and fired one round, while Holbrook dropped to his knee and fired one more round. Mr. Morgan dropped from view, falling off the edge of the elevator structure and into a small trench just below the roof of the structure. The shooting occurred roughly 20 minutes after officers' arrival on scene.

Sergeant Holbrook maintained command of the scene until another sergeant arrived to relieve him, despite being involved in the deadly force incident. He considered having officers approach the area where Mr. Morgan had dropped, but quickly concluded they could not safely do so. Mr. Morgan was believed to be armed and had pointed his gun at officers. Neither he nor Officer Scott could be certain their bullets had struck Mr. Morgan, so it was unclear to them whether he was down and injured or just lying in wait. In order to locate him, officers would have had to climb up and then peer over the ledge and expose themselves to a possible ambush. Instead, Sergeant Holbrook decided to call out the Special Emergency Reaction Team (SERT), who had the specialized tools and training to manage the approach and rescue. He and Officer Scott retreated to a position of cover and were ultimately relieved and removed from the scene. Other officers continued to cover and monitor the area around the elevator structure while waiting for SERT officers to respond.

Approximately 35 minutes after they were called out, SERT assumed command of the scene. There was some delay in this transfer created by the failure to have on-scene personnel available to brief and guide the SERT officers. This delay was addressed in the SERT after-action report. SERT ultimately deployed a robot camera to locate Mr. Morgan, roughly one hour after the shooting. It took

additional time and the acquisition of a 20-foot ladder from the local fire station in order for officers to reach Mr. Morgan and confirm he was deceased. The gun that Mr. Morgan had was actually a replica gun that he had spray painted black to make look more realistic.

Following the autopsy, the State Medical Examiner concluded the cause of death was a gunshot wound of the brain. The pathologist who performed the autopsy testified at grand jury that the bullet struck vital parts of the brain controlling the heart and respiration, so Mr. Morgan "collapsed and died very quickly." Only one bullet struck Mr. Morgan, though another passed through his sweatshirt without causing injury.

The Multnomah County Grand Jury met and concluded that the involved officers had no criminal liability for Mr. Morgan's death. The Bureau found the officers' tactics and use of deadly force to be within policy.

Timeline of Investigation and Review

1/25/2012	Date of Incident
2/15/2012	Grand Jury concluded
9/17/2012	Internal Affairs Investigation completed
11/14/2012	Training Division Review completed
2/1/2013	Commander's Findings completed
3/20/2013	Police Review Board convened

Analysis/Issues Presented

Tactical Decision Making

The officers dispatched in this incident had to weigh the competing goals of building rapport and trust with Mr. Morgan to convince him to come down from the ledge and of keeping enough distance to protect themselves from harm. With the belief that they could not build rapport in any manner other than a face-to-face

conversation, and with great confidence in their ability to communicate with people in crisis,[16] Officer Scott and Sergeant Holbrook made the decision to abandon positions of cover and close the distance between themselves and Mr. Morgan. In doing so, they placed themselves in a dangerous position from where, ultimately, they felt the need to use deadly force to respond to the threat Mr. Morgan posed. Both the Training Division Review and the Commander's memorandum provide thoughtful analysis of that decision. Though they ultimately disagree with each other on the question of whether the officers' actions in moving closer to engage Mr. Morgan were consistent with training, they both conclude that the use of deadly force was reasonable and within policy.

The Training Review, in particular, is quite detailed in its discussion of the training that the officers would have relied on to convince themselves that engaging Mr. Morgan face-to-face was the appropriate course. Like all Police Bureau officers, both Officer Scott and Sergeant Holbrook had been through Crisis Intervention Team training. That training emphasizes personal communication skills that are dependent on face-to-face contact. While the Review concluded it was not unreasonable for the officers to approach Mr. Morgan, it also states that given the information regarding "suicide by police" articulated by the dispatcher, it would have been consistent with training for Sergeant Holbrook to place greater value on maintaining distance between officers and Mr. Morgan while requesting additional resources, including the Crisis Negotiation Team. The Training analysis notes that officer safety should always outweigh a desire to intervene to prevent suicide and that, by placing a priority on their own safety, officers also reduce the likelihood that subjects will force a confrontation with police that could end with the use of deadly force.

The Commander's memorandum disagrees with the conclusion made by Training, finding that the decision to move forward was not contrary to training. The memorandum emphasizes statements made by both officers about their desire to establish a personal connection with Mr. Morgan and their belief that a successful resolution depended on their willingness to approach him. The Commander concludes that while the wisdom of the decision to move closer to Mr. Morgan may be the subject of disagreement, it was neither reckless nor impulsive. The officers made a judgment call at the time, based on all the circumstances

[16] The interviews in this case contain repeated references to the frequency with which Central Precinct officers deal with suicidal people threatening to jump, mainly off of Portland's numerous bridges. Most estimated that the precinct handles two to three such calls per week, often to successful resolution.

presented to them, and the Commander found their performance to be within policy.

While we found the Commander's memorandum to be thorough in its approach and careful in its analysis, a comment it makes indicates a flaw in its reasoning: "Bradley Morgan was committed to his suicidal plan and no amount of negotiation would have prevented him from forcing the officers to take his life." Even if that statement was true, it does not relieve officers of the obligation to observe sound principles of officer safety and avoid placing themselves in a situation where they feel compelled to use deadly force. And as we discuss in more detail in the Common Issues section of this report, the notion that officers would be "forced" into taking particular action surrenders too much power and control to a suicidal subject. Finally, as discussed further below, a review of the recording of Mr. Morgan's 911 call signals that Mr. Morgan may not have been as intent on ending his own life as the Commander suggests in his memorandum.

Communication with the Bureau of Emergency Communications

The Bureau of Emergency Communications dispatcher who handled Mr. Morgan's 911 call spent nearly 25 minutes on the phone with him before the officers arrived and took over communications. In that time, the call taker established a rapport with Mr. Morgan, gathering information, listening to his story, and showing empathy. According to a Bureau crisis communications trainer who had taught a block on crisis intervention and suicidal calls to dispatchers during an Emergency Communications Bureau in-service training several months prior to this incident, the call taker who spoke with Mr. Morgan clearly used that training in her conversation with Mr. Morgan.

Unfortunately, much of that positive rapport was lost when officers arrived and Mr. Morgan and dispatch quickly ended their conversation. At one point, a frustrated Mr. Morgan told the officers that he had already told the other "cop" all the information they were asking about. But both the dispatcher and the scene officers were following standard protocol at the time.

Following this incident and as a direct result thereof, the Training Division has begun to introduce to patrol officers some of the practices and skills that Crisis Negotiation Team members use on a regular basis. Specifically relevant here are strategies intended to transfer positive rapport from a 911 call taker to a field officer that are now being taught in Enhanced Crisis Intervention Team training and in regular in-service and Advanced Academy classes. Rather than simply

have the dispatcher hang up when officers arrive, officers and call takers dealing with people in crisis are encouraged to have officers conference in to the 911 call before the dispatcher hangs up. This allows the call taker to introduce the officer to the person in crisis in a way that lets that person know the call taker trusts the officer to continue the conversation in a positive way. The call taker can then give the officer a synopsis of the call, letting the person in crisis know that the call taker has been listening and giving the person a chance to correct anything the call taker gets wrong, while at the same time informing the officers about the content of the prior conversation before their direct engagement. It is impossible to say, of course, whether this procedure would have led to a different outcome for Mr. Morgan, but it is possible to see how the conversation with Officer Scott and Sergeant Holbrook might have been more productive if they could have stepped into conversation while the call taker was still engaged.

In addition to the loss of positive rapport, many details of Mr. Morgan's conversation were not relayed to the officers on scene. Most importantly, the call taker told the officers simply that Mr. Morgan was "making suicide by police statements." In fact, Mr. Morgan's expression of his intent was much more specific. Likewise, his threats about killing a police officer were more explicit than the statement that he might have a gun. Throughout their interviews, both Sergeant Holbrook and Officer Scott seemed to downplay the possibility that Mr. Morgan had a gun, or that he might use it to either shoot at them or provoke them into shooting at him. If officers had known the full context of Mr. Morgan's statements, they may have been less likely to minimize the threat and maintained a greater distance from him.

Recognizing that it is not possible for a 911 call taker to relay to officers every detail of a call, or to be able to identify every bit of information that officers in the field might find relevant or important, the Training Division has started to teach officers to request dispatch to email them the audio file of a 911 call while they are en route to the scene or as they plan their approach. With MDC technology in patrol cars, this is a simple and straightforward request. While this may not have been practical in this case because Mr. Morgan's conversation with the call taker lasted so long, officers generally report they find it helpful to actually listen to the 911 call rather than rely on the dispatcher's characterization of the caller's statements.

These Training initiatives stemming from this tragic incident are dependent on a positive working relationship between the Police and Emergency

Communications Bureaus, and it appears the two agencies understand that imperative. Police Bureau personnel are providing in-service training to all dispatchers on handling crisis communication and suicidal calls. When the Bureau established its Enhanced Crisis Intervention Training program, it reached out to the Emergency Communications Bureau for input on how they could collaborate better on calls. And the Police Bureau is currently working to have dispatchers assigned to its Crisis Negotiation Team, both to tap into their expertise and to provide cross-exposure.

In past reports, we have commented on some ways in which communication breakdowns between dispatchers and patrol officers potentially contributed to negative outcomes. In our Third Report, we recommended that the City require Bureau of Emergency Communications dispatchers to attend Critical Incident Management Training. We note that having Police Bureau crisis communication trainers teach during regular in-service training for dispatchers may be a more practical and efficient way to accomplish a similar objective, and recommend the Emergency Communications Bureau make this a regular part of its annual training.

In our Second Report, we recommended that Bureau of Emergency Communications supervisors be included in the Police Review Board hearings for incidents where a dispatcher's performance – good or bad – is at issue. (Recommendation 19, Second Report, p. 62) We renew this recommendation as a way to continue building a positive relationship between the Police and Emergency Communications Bureaus and to ensure that lessons learned by the Police Bureau in the course of its review are effectively transferred to Emergency Communications.

Recommendation 7: The City should ensure that Police Bureau crisis communications instructors regularly provide training to dispatchers, either as part of the Police Bureau's Critical Incident Management Training or during the Bureau of Emergency Communications' annual in-service training.

Recommendation 8: The City and Bureau should consider ways to formally bring Bureau of Emergency Communications supervisors or decision makers into the Police Bureau's review process in cases where a dispatcher's judgment or performance is potentially at issue.

Sergeant in Tactical Role

Despite the presence of a number of other officers on scene, Sergeant Holbrook assigned himself to be part of the communication team approaching Mr. Morgan and ultimately fired his weapon at Mr. Morgan. As we have noted in the past and in other cases we review for this report, sergeants on the scene of a tactical incident should take command of the incident and direct resources appropriately without engaging directly in a tactical role. While it is impossible to say whether this incident might have been managed differently had Sergeant Holbrook maintained a purely supervisory role, as a general principle it is preferable for sergeants to maintain a bigger picture view of the entire incident than to assume a tactical role.

The Bureau overhauled its training for supervisors in 2011, just before this incident, and the curriculum instructs sergeants to be the team's decision maker and work through their officers to resolve an incident rather than personally engage.

The Training Division Review here was critical of Sergeant Holbrook's decision to put himself on the communication team, calling it not consistent with training. The Commander's memorandum acknowledged that supervisors are trained not to insert themselves into tactical situations, but found that Sergeant Holbrook's role here did not have a negative impact on the management or outcome of the incident. The basis for this finding is unclear, since we can never know whether a scenario in which the sergeant played a supervisory role would have ended differently.

Post-Shooting Tactics

Following the shooting, Sergeant Holbrook made the decision to transfer the call to SERT officers because Mr. Morgan pointed a gun at officers and was in an unknown position and condition. For officers to reach the area into which he had fallen required specialized equipment and exposure to the possible threat Mr. Morgan posed. There was a brief delay in transferring information to SERT officers when they arrived, 35 minutes after being called out, but SERT ultimately took command of the scene. They used a robot camera to locate Mr. Morgan, and officers deployed shields to approach. Recovering Mr. Morgan's body from the top of the elevator structure required a 20-foot ladder and Fire Department personnel. In all, just over an hour and 20 minutes passed between the time of the shooting and the medic's confirmation that Mr. Morgan was deceased.

Changes in Training and Approach

The Training analysis following this shooting focused on the concern that officers moved in to talk to Mr. Morgan without appropriate regard for their own safety, ultimately putting themselves in a position where they felt so threatened by Mr. Morgan's actions that they needed to respond with deadly force. In reviewing the shooting, Training considered the differences between how patrol officers are trained and the principles that guide the Bureau's crisis negotiators. A relatively simple and straightforward point that Training now emphasizes in its crisis communication curriculum is that officers should consider contacting subjects by phone. Patrol officers are accustomed to dealing with people up close, face-to-face, and are trained to read body language and respond to other non-verbal cues. Crisis Intervention Training, which all patrol officers attend, emphasizes building rapport with individuals through face-to-face communication. Crisis negotiators working with the Crisis Negotiation Team, by contrast, frequently interact with individuals via telephone. Here, officers knew Mr. Morgan had a cell phone as he had been talking with the 911 call taker. The involved officers considered calling Mr. Morgan, but both reverted to their training and stated they believed they could more effectively build rapport in a face-to-face conversation.

Following this shooting, the Bureau made a number of other changes in the way it trains its officers to approach suicidal subjects or people in crisis. As discussed above, Training now emphasizes that both officers and dispatchers should think about how to transition a call from a 911 call taker to on-scene officers, so that the positive connection call takers may have established can be transferred to the officers who will continue communications. In situations where a 911 call has already terminated, officers are now trained to ask dispatchers to email them a recording of the call, so that they can hear both the content and tone of what a caller said rather than relying on the call taker's characterization.

Officers continue to be instructed to call the Crisis Negotiation Team when the circumstances require, but recognizing that patrol officers are the first responders and it often takes crisis negotiators some time to arrive, these crisis negotiation principles are being taught to all patrol officers at the Advanced Academy and, on a more extensive and detailed basis, to officers who go through Enhanced Crisis Intervention Training. Training Division has used this shooting as a learning tool to help officers better understand how to react to people threatening suicide or otherwise in crisis. The Bureau's trainers expect that officers would handle a

situation like that presented by Mr. Morgan somewhat differently today than they did in 2012.

Quality of Investigation and Review

Both the Detectives' and Internal Affairs investigations were thorough in the evidence gathered and interviews conducted. There were a few questions that investigators did not ask the involved officers but that would have been useful to reviewers. For example, we discussed above how the 911 call taker did not provide responding officers all the details of Mr. Morgan's "suicide by police" statements, or his threats to kill an officer. It would have been useful to ask officers whether, or how, this additional information from the dispatcher might have changed their assessment of the threat Mr. Morgan posed.

The Training Division Review is thorough, provides thoughtful analysis, and offers constructive critique. The Review also recommends that all sworn officers attend the 20-hour critical incident management class that all supervisors are required to complete. That recommendation was endorsed by the Bureau, but turned out to be too difficult to implement fully. Instead of sending every officer to the 20-hour class, which would have encompassed half of their typical 40-hour annual in-service training, the Training Division added a block of classroom training from the critical incident management class to the annual in-service, and then incorporated crisis communication principles in the scenario training that officers must complete during annual training. While it may be ideal to have every officer attend 20 hours of critical incident management training, the Bureau has to deal with the reality of tight budgets and numerous training demands. When the Training Division realized it was not feasible to send everyone to the 20 hour class, it made a reasonable adaptation to the training, so that all officers received some additional instruction and training on managing critical incidents.

Delay in Investigation and Review

The Police Review Board did not review this incident until 14 months after it occurred. Internal Affairs did not complete its investigation until eight months after the incident, and four months after completion of the Detectives' investigation. There was a further delay in completing the Training Division Review – two months after the Internal Affairs investigation was complete. And the Commander's findings memorandum was not finished until two and a half months after the Training Review. We note these delays, as we have noted them

in many prior cases we have reviewed, but also recognize that the Bureau's processes for administrative investigation and review have changed significantly since 2012, in response to external criticism as well as the agreement between the City and the Department of Justice.

March 26, 2012 ◦ Jonah Aaron Potter

Portland police responded to the scene of an armed robbery of a convenience store where the suspect was captured on surveillance video brandishing what appeared to be a large semiautomatic handgun. A witness who had been inside the store at the time of the robbery described the gun as possibly fake. This witness followed the suspect outside the store and got a description and partial license plate number of the car he drove away. Though the suspect had his face covered by a ski mask or balaclava, his wife recognized the description of the car, as well as the suspect's shoes and body movement from the video she saw on a local news broadcast. She identified her husband, Jonah Potter, to police, gave them a full description of the car and license plate number, and told them her husband had been depressed for some time and had progressed from a prescription drug addiction to heroin use.

The following morning, an officer on his way to court saw the car, a blue Honda Civic, parked on the street at SE 37th Avenue and SE Oak Street. The car was occupied and an individual, later identified as Mr. Potter, apparently was asleep in the driver's seat. The officer broadcast this information and watched the car until a team of officers arrived. Officers initially planned to box in the subject's car to prevent him from driving away. Before they implemented that plan, though, a sergeant responded and assumed command via radio while he was en route to the scene. He instructed officers to stay back from the car, out of the occupant's view, and delegated responsibilities to different officers. One officer served as a spotter whose role was to watch the car and its occupant and alert the others if the subject woke up or began to move. Other officers were instructed to place spike strips further up the road, with the intent of disabling the car if the subject started to drive away. A team of six officers was assigned to perform a high-risk traffic stop, if necessary, and set up around the corner on Stark and 37th.

Because the subject was reported to have been armed the day before, the sergeant got approval from his chain of command to activate the Special Emergency Reaction Team (SERT), intending that team to bring an armored vehicle to block the suspect vehicle in, without putting an officer at risk. The sergeant's plan was to let the subject sleep until SERT arrived and could address the scenario with its specialized equipment. He also developed a contingency plan in case the vehicle's occupant awoke before then. If the spotter alerted the team to movement in the vehicle, the sergeant planned to initiate a high-risk stop on the car to prevent it from leaving the area. The stop team included two SERT officers

working regular patrol assignments – Dennis Wilcox and Larry Wingfield – as well as four other officers, including Tracy Chamberlin and Richard Storm.

Shortly after this plan was established, and before the sergeant arrived on scene, the spotter informed officers that the subject appeared to be awake and was moving about inside the car. The sergeant instructed the stop team to move in, and the six officers in four marked patrol vehicles drove up on Mr. Potter's car, with their lights activated. They stopped in positions that mirrored their training for high-risk traffic stops. The officers got out of their cars with their guns trained on Mr. Potter's car. One officer began giving loud commands for the subject to roll down his window and put his hands out. Mr. Potter did not comply with those commands. Instead, officers reported seeing him digging around inside the car. At one point, he opened the driver's door partially and looked around at the officers, but then closed the door. Shortly after, he opened the door and quickly got out of the car. As he spun toward the officers, they all identified a gun in his hands. Four officers fired a total of seven rounds. Officer Wilcox fired one round from his M4 rifle. Officer Wingfield fired three rounds from his M16 rifle. Officers Storm and Chamberlin each fired one or two rounds from their 9mm handguns. All officers articulated their backdrop as being either a large rock wall, a group of bushes and trees on a rise, or a dirt berm in front of an elevated lot.

One round struck Mr. Potter's arm, causing his gun to fly out of his hand and land several feet away. Officer Wingfield acknowledged that training and protocol would be to assemble a custody team to approach the subject (who was obviously still alive) with a ballistic shield, but he believed he could safely secure the subject's gun and nullify the threat, so he left hard cover and while other officers covered the subject with their weapons, Officer Wingfield walked over and retrieved Mr. Potter's gun, which officers only then could identify as a pellet gun. After securing the gun, the officers moved in and handcuffed and searched Mr. Potter. Officer Wingfield turned Mr. Potter over, concerned that the bullet might have hit an artery and required immediate attention to stop the bleeding. Though the injury to Mr. Potter's arm was serious, it was not life threatening. A medical team arrived quickly and immediately entered the scene to attend to Mr. Potter and transport him to the hospital.

Two and a half weeks after the shooting, while still hospitalized, Mr. Potter directed officers to a note he had left inside his car. The note was "to the officer(s)" and stated, "I'm very sorry that I had to get you involved, and make you do my dirty work. I tried to purchase a real gun to do it myself, but couldn't.

I really hope this doesn't affect you or your job in any way, and again I'm very sorry." Mr. Potter also had left a suicide note for his wife.

Within two weeks of the incident, the Multnomah County Grand Jury met and determined the involved officers' use of deadly force was justified under criminal law. Because the same grand jury charged Mr. Potter with criminal counts relating to the robbery and later confrontation with police, the District Attorney's office did not publicly release transcripts of the proceedings. Mr. Potter later pleaded guilty and was sentenced to prison for attempted second-degree robbery and menacing.

The Bureau found the officers' tactics and use of deadly force to be within policy.

Timeline of Investigation and Review

3/26/2012	Date of Incident
4/9/2012	Grand Jury concluded
11/6/2012	Internal Affairs Investigation completed
12/7/2012	Training Division Review completed
1/9/2013	Commander's Findings completed
2/20/2013	Police Review Board convened

Analysis/Issues Presented

Tactical Planning

The sergeant in command of this incident and the officers involved followed their training to such a degree that the Training Division Review had no recommendations following this incident, other than to use it an excellent example of leadership, planning, tactics, and teamwork. We agree with Training's conclusions. Bureau personnel developed a plan that maximized both the safety of the officers and the subject, communicated clearly regarding each

officer's role, adapted to a changed circumstance to implement a contingency plan, and executed the plan in a tactically sound way.

Quality of Investigation and Review

Timing of Officer Interviews

The question of when Police Bureau officers involved in a critical incident will be interviewed is one that has been in flux throughout much of the time period for which we have reviewed those incidents for the City. Of the cases we review in this report, the timing of interviews in this case most closely resembles the Bureau's current practice. Following current standard practice, the four officers who used deadly force all declined to give statements to Detectives on the day of the incident. The witness officers were interviewed that day. The Detective Division then served all the involved officers with communication restriction orders, ordering them not to speak or communicate with anyone regarding the case, with the exception of investigators, spouses, clergy, medical or psychological professionals, and union representatives or attorneys.

The Internal Affairs investigator then served the four officers who used deadly force with a notice that they were to submit to compelled administrative interviews at a given time, at least 48 hours after the incident. Before the scheduled Internal Affairs interview, however, all four officers submitted to voluntary interviews with Detectives and were interviewed two or three days after the event. As a result, Internal Affairs postponed its interviews until after the grand jury completed its review of the case. We have repeatedly raised concerns with the so-called 48-hour rule, which prohibits the Bureau from requiring officers involved in a use of deadly force to submit to an administrative interview for at least 48 hours. As we state in the Common Issues section of this Report, we remain concerned that the Bureau is required to wait two days before getting any interview from involved officers about their use of deadly force.

Our understanding is that current practice is similar to what occurred here, with the exception that rather than wait until after the grand jury concludes to conduct interviews with involved officers, Internal Affairs investigators now sit in and listen to Detectives' interviews and, when Detectives are done and have left the room, will ask any additional or follow up questions they might have. We have not seen this dynamic at work in any of the cases we have reviewed, so we cannot judge its effectiveness, but urge the Bureau not to think of it as a solution to the

problems presented by the 48-hour rule currently governing officers' availability for interviews. While the new practice provides some advantages over past involved officer interview protocols, in that it at least provides Detectives the opportunity to interview officers, the Bureau should not be required to wait for two or three days to hear why an officer used deadly force against a citizen. As we discuss further below, until the collective bargaining agreement that prevents the City from obtaining an account from officers on the day of the shooting is amended, investigations into critical incidents will continue to be negatively impacted.

We offer one caution to Internal Affairs investigators as they begin to operate under this new procedure. We have seen many cases where investigators benefit from the opportunity to read the full Detectives' investigation and review, and where applicable, officers' grand jury testimony prior to creating a list of questions to ask an officer during his or her administrative interview. The new order of interviews has the benefit of allowing Internal Affairs to ask questions while an event is still fresh in the officer's mind but deprives them of the opportunity to prepare for the interview by reading the full Detectives' casebook. As a result, Internal Affairs investigators should expect to conduct follow up interviews to answer questions that are triggered by an issue raised or discovered in the full Detectives' investigation.

Medical Records

We recommended in our last report (which post-dates this incident) that Detectives and Internal Affairs investigators should attempt to gather records of a subject's medical treatment following a non-fatal officer-involved shooting. We noted that investigations into fatal shootings always include an autopsy report that contains significant evidence to describe how and where bullets entered the body, what path they took within it, and the damage done to internal organs. Here, as in the case that prompted this recommendation in our prior report, neither Detectives nor Internal Affairs investigators made any apparent attempt to get copies of Mr. Potter's medical records or to talk to any medical personnel who treated him about the nature of his injury.

Of course, a subject has a privacy interest in not sharing his medical records with investigators and may refuse to waive the confidentiality of those records, but it does no harm for investigators to request access to a subject's medical chart or providers. Moreover, detectives who are conducting a criminal investigation have the ability to obtain a search warrant for the records. As we said in our earlier

report, making all possible efforts to obtain the records of the subject's medical treatment immediately after the shooting should be a routine part of any officer-involved shooting investigation. In its response to that report, the Bureau agreed with this recommendation and has reportedly implemented it.

July 17, 2012 ◦ Juwan Blackmon

Just before noon on July 17, 2012, the Tactical Operations Division Gun Task Force was conducting a surveillance of a location when an officer observed an individual later identified as Juwan Blackmon[17] showing a handgun to other individuals in a parking lot outside the location. Mr. Blackmon briefly entered the location, then exited and got into a car with three other people. He was seated in the back seat on the driver's side. The officer who observed the handgun relayed his observation of the gun, as well as pictures of Mr. Blackmon to the rest of his team. The task force sergeant decided that when the car drove away from the surveillance, two task force officers who were positioned away from the surveillance to perform such traffic stops would stop the vehicle to arrest Mr. Blackmon.

Another task force officer who had been in discussions with the task force sergeant asked East Precinct officers to assist on a high risk traffic stop of the vehicle. As the task force officers were following the vehicle and waiting for additional back up, the vehicle pulled into a turn lane to turn into an apartment complex parking lot. Seeing that they had some assistance from arriving East Precinct officers, and not wanting the vehicle to enter the parking lot and park, the task force officers initiated the traffic stop by turning on their overhead lights. The vehicle came to a stop in the driveway of the apartment complex.

Officer Gregory Moore was in a marked vehicle directly behind the task force officers. The second-arriving East Precinct officer was behind Officer Moore. Following Bureau training on high risk traffic stops, the officers positioned their cars and got out to the appropriate positions to provide cover. Officer Moore and the second-arriving East Precinct officer took cover behind the front of the second-arriving East Precinct officer's car, covering the driver side of the suspect vehicle.

The task force officer who was the passenger in the lead stop vehicle broadcast commands to the occupants of the car to keep their hands on the ceiling of the car and look forward. The front seat occupants complied. Mr. Blackmon and the other back seat occupant had to be reminded to continue to follow the instructions as they were dropping their hands and looking behind.

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[17] Mr. Blackmon was 17 years old at the time of this shooting. While we hesitate to use the name of a juvenile, we note that he was identified by name in both media accounts and Bureau statements at the time of the shooting.

There had been radio broadcasts requesting responses by an officer with a K9 and by one with a less lethal beanbag shotgun. Officers decided that because their prime target, Mr. Blackmon, was in the back seat of a two door vehicle and therefore had no path of exit, they would wait to begin the extraction of the suspects from the vehicle until after these resources arrived. Officer Dennis Wilcox arrived with less lethal and took a position next to Officer Moore and the second-arriving East precinct officer. The K9 officer arrived with his K9 and took a position behind the others.

Once the dog and less lethal beanbag shotgun had arrived and custody teams were established, roughly five minutes into the stop, the front seat occupants of the vehicle complied with officers' commands to get out of the vehicle and were taken into custody without incident.

Mr. Blackmon was then told to push the driver's seat forward and exit out the driver's door. The officers were aware that he was the suspect seen with the gun. He exited the car. He was told to raise his hands, but only did that part way. He continued to look around at the officers and twist his body. He was told to grab his shirt by his collar and raise it exposing his waist. He started to reach toward his collar, but did not raise it. He then dropped his hands while spinning around to his right. When Mr. Blackmon dropped his hands, Officer Moore fired one round from his pistol. Officer Wilcox fired one less lethal round. Officers were not certain whether Mr. Blackmon had been struck, or by which rounds. Mr. Blackmon started running away from the officers, fleeing behind tall shrubs and into the apartment complex.

Officer Jeff Dorn released his K9 with a command to chase Mr. Blackmon. The dog started to follow Blackmon, but instead turned and focused on the remaining occupant of the stopped vehicle and bit the occupant. Officer Dorn had to issue multiple commands to remove the dog from that occupant. Radio traffic was sent out to try to contain Mr. Blackmon, while the officers on the scene took the final occupant into custody without incident. Officers, including assisting officers from neighboring jurisdictions, established a containment and gave chase, broadcasting location information when available, and after a short search Mr. Blackmon was located and arrested without further incident a few blocks away. Mr. Blackmon had been struck by Officer Moore's bullet and sustained a through wound to his upper right thigh. He received medical treatment at a hospital and was released to Bureau custody. Two guns were retrieved from a yard along Mr. Blackmon's path and he ultimately admitted both were his.

Timeline of Investigation and Review

7/17/2012	Date of Incident
8/3/2012	Grand Jury concluded
9/26/2012	Internal Affairs Investigation completed
1/24/2013	Training Division Review completed
3/12/2013	Commander's Findings completed
5/28/2013	Police Review Board convened

Analysis/Issues Presented

Gun Task Force Surveillance

The Tactical Operations Division Gun Task Force surveillance had been planned in advance as part of the execution of a search warrant. As part of this planning, the task force anticipated that it might need to do a traffic stop on individuals leaving the target location. While East Precinct personnel were aware of task force activity at that location in the past, the task force did not alert East Precinct to their operations that day. It is a testament to the quality of the personnel and the strong training by Bureau that the East Precinct officers and supervisors were able to seamlessly slip into the necessary roles. Neither the Commander's Review and Findings nor the Training Review looked at this issue. However, it would have been preferable for the task force to have provided East Precinct with notice that they had a tactical operation in the area and might be calling on East Precinct for assistance.

Recommendation 9: Specialized units performing planned operations in a patrol area that could require assistance from patrol personnel (or could be interfered with unwittingly by patrol personnel) should alert the patrol supervisors and personnel unless there is a documented reason why such an alert could jeopardize the operation.

High Risk Traffic Stop

As the Training Review noted, the officers executed a text book high risk traffic stop. The Bureau should be commended for the level of training it is giving its officers. Two of the involved officers were in the final phase of their probationary periods with the Bureau. Nonetheless, everyone knew their roles and fulfilled them.

Three issues came out of the interviews that the Bureau may want to consider for future training. During the extraction of the occupants from the vehicle, the task force lead vehicle passenger officer ordered the passengers to lift their shirts from the collar to expose their mid-section and turn in a circle. According to another officer on scene who had recently attended the Advanced Academy, the Academy has stopped teaching this technique, but during his training at the Academy some senior officers were present and they said that they were not aware of the change in training. If there has been a tactical decision to abandon this technique, the Bureau needs to ensure that is communicated to all officers so they are not using outdated tactics or techniques that have been deemed by the Bureau to be unsafe.

Second, one of the officers on the custody team indicated that she could not hear the commands being given by the lead officers to the occupants as they were extracted from the car. Not being able to hear those commands could cause an officer to misinterpret the behavior of an occupant and react inappropriately based on that misinterpretation. The Bureau should examine whether the inability to hear the commands is an isolated problem or something broader that should be addressed.

Third, the task force officer who was the passenger in the lead vehicle indicated that he was both the primary officer issuing commands to extract the occupants from the car, and providing cover on the passenger side of the vehicle with his gun drawn and aimed at the occupants. With the number of officers present, the Bureau review process should have explored whether another officer should have been given that cover responsibility to allow the task force officer to focus on each individual he was extracting.

The Training Review noted that the Bureau should continue to be rigorous in its training for high risk traffic stops and in creating varying scenarios. We concur.

Recommendation 10: The Bureau should continue with its rigorous scenario based training, and should ensure that when it decides on a change in tactics or techniques, that change is communicated to all personnel, not just those who attend more recent training.

Use of Less Lethal Bean Bag

In his interview, one of the task force officers stated that he understands that the less lethal bean bag, as well as the Taser and the K9, can be used when a suspect fails to comply with commands. He stated they are used "to get their attention" in order to obtain compliance. Other officers on the scene heard the warning to Mr. Blackmon that if he did not comply he would be shot. This is an apparent misstatement of Bureau policy, and the Bureau should review its training to ensure that it clearly articulates the correct policy and then determine whether the officer's misunderstanding is a widely held view that needs Bureau-wide correction.

Quality of Investigation and Review

Scope of Police Review Board Review

The review of the use of deadly force was broad, covering not just whether Officer Moore had an objectively reasonable basis to believe Mr. Blackmon posed an immediate threat of death or serious physical injury, but also whether Officer Moore was negligent or reckless in firing given the background. The Bureau should be commended for continuing to look at shooting incidents holistically.

The Police Review Board review also appropriately examined the use of less lethal force. However, neither the Training Review, Commander's Review and Findings, nor the Review Board review touched upon the use of the K9. This is an unfortunate gap in the review of the entire incident. It is important to examine whether the K9 was used appropriately in this situation, and whether there are any lessons that can be learned from the deployment here, including from the fact that the K9 targeted the wrong individual. In addition, we have seen in other agencies situations where the mix of deadly force and a K9 results in unintended consequence.

Recommendation 11: When a K9 is used in a shooting incident, evaluation of the K9 deployment should be part of the Training Division Review, Commander's Review and Findings, and Police Review Board discussion.

Internal Affairs Investigation

The Internal Affairs investigators did a very good job in their interviews. Of specific note was the quality of their follow up questions. On multiple occasions, when an interviewee answered with a conclusory statement, the investigators followed up with questions that specifically asked the interviewee what she observed that led to her conclusion. This is an important part of obtaining a complete, informative interview, but often missed. They should be commended for this.

On a minor note, in this incident, important information that supported the conduct of the officers was broadcast over the radio. While the radio traffic is included in the file, there is no documentation that the investigators reviewed the radio traffic and found it consistent with the officers' statements. This should be expressly included in the Investigative Report.

Unprofessional Comments

During her Internal Affairs interview, one of the responding officers used the phrase "shuck and jive" to describe the conduct of Mr. Blackmon. There was no note of anyone taking any action, including simply explaining to her that that is a phrase that is certainly unprofessional, could be considered racially offensive, and should not be used. For those situations not rising to the level of a violation of policy, there should be at least an informal process for investigators to flag such issues for supervisors so that they can conduct appropriate counseling.

Commander's Review and Findings

The Commander completed his review and findings very quickly. According to Internal Affairs' internal tracking system, this took just 4 days. In the past this has been a task the Bureau has struggled to complete in a timely manner and therefore we are impressed with how promptly this one was done.

In this matter, however, only by the East Precinct Commander completed the review. There is no indication that the task force Commander was given an opportunity to review the incident or proposed findings. While it was East

Precinct personnel that used the lethal and less lethal force and were the primary targets of the review, nonetheless, task force personnel had a key role in the incident and it would have been important to have the incident critically reviewed by their command as well.

Recommendation 12: When specialized units are involved in an incident along with patrol units, both Commanders should have a role in preparing the review and findings, based on the relative level of involvement of their personnel.

Timeliness of Training Review

The Training Division Review in this case was not completed until four months after completion of the Internal Affairs investigation. The Auditor's Independent Police Review Division initially delayed its review of the investigation because the Training Review was not complete and ultimately signed off on the investigation without the benefit of Training's analysis.

We understand that at the time of these incidents, there were transitions of personnel that may have led to the confusion and issues with the assignment and completion of the Training Review. Nonetheless, even after corrections were made in the assignment of the Training Review, the completion of the Training Review was quite delayed. If issues still exist in the assignment and completion of the Training Review, the Bureau should address these.

Cooperation with Surrounding Jurisdictions

In his interview, when asked about any concerns about the incident, an involved sergeant mentioned several issues that arise when the Bureau is assisted by neighboring jurisdictions and that he thinks it would be helpful to have addressed through joint protocols, similar to the Bureau's collaboration with those jurisdictions on vehicle pursuits.

Specifically, he mentioned that when the assisting officers arrive, they do not check in on the radio like Bureau officers do. Therefore, he may not be aware of their presence or precise location and is not able to use them as effectively as if he were notified of their arrival and could direct their deployment.

In addition, he stated a concern that after Mr. Blackmon had fled, some of the assisting units from neighboring jurisdictions were pursuing him, but broadcasting their information on their radio network only, with the information then relayed to

the Bureau. This resulted in a delay of information to Bureau personnel, and also created a risk to these units because in the event of an emergency, Bureau personnel could not directly assist them. There is no apparent documentation whether the Police Review Board considered or addressed these concerns.

In addition to the areas the sergeant identified, a third area for review between the Bureau and its neighboring jurisdictions is training on high risk traffic stops. As this incident demonstrates, Bureau personnel are so highly trained in high risk traffic stops, that everyone knows their role and the standard procedure. However, this also means that if other jurisdictions are assisting, they need to have the same level of understanding of roles and the procedure.

Recommendation 13: The Bureau should review critical incidents with neighboring jurisdictions and attempt to develop universal procedures and best practices for assisting units to alert the handling jurisdiction that they have arrived to assist, as well as radio communication protocols to ensure the most timely and complete sharing of information and to advance principles of officer safety.

July 28, 2012 ◦ Billy Wayne Simms

Just after noon on the date of the incident Police Bureau officers in East Precinct responded to two related calls involving suspects with a gun, one involving shots being fired. They received a description of the suspects and the car they were driving. They broadcast this information on the East Precinct radio frequency. They subsequently learned that the car was a rental car and was outfitted with GPS. Through the rental car agency, the East Precinct sergeant was able to obtain the location of the car as it traveled through Portland and into the North Precinct area.

The East Precinct sergeant then sought assistance from North Precinct officers to locate the vehicle, informing them over North's radio frequency that it had been involved in a shooting incident. During the course of the search for the vehicle, the East Precinct sergeant also broadcast that at the scene in East Precinct, they had recovered a gun magazine. A North Precinct officer accepted the assignment. A second officer responded that he would assist. Three additional North Precinct officers and a North Precinct sergeant also joined the search for the vehicle.

The East Precinct sergeant used the North Precinct radio frequency, to broadcast the changing location of the vehicle as it was being provided by the rental car company's GPS system. He provided several locations, but when the officers arrived, the car was no longer there, or before they could arrive a new location was provided. Finally, the East Precinct sergeant informed the North Precinct officers that the GPS had the car located at 6840 N. Fessenden Street. The officers confirmed from personal knowledge that this was a 7-11 store next to a gas station at "Six Points," a busy intersection.

The second officer to respond that he would assist was the first to arrive at the 7-11 store. He pulled into the parking lot in view of the store. Once in the parking lot, he confirmed the vehicle was parked in front of the 7-11 store, facing west towards the store. He transmitted over the radio that he had located the vehicle at the 7-11. The car was unoccupied, but the officer saw two males inside the 7-11 whom he believed to be the suspects. He asked over the radio for a description of the suspects. As the two males began to exit the store, a suspect description was provided that matched one of the males, the driver.

In the meantime, the officer who had been first to accept the assignment arrived and parked near the apron to the 7-11 parking lot a small distance behind (north) of where the first arriving officer was parked. The second arriving officer

approached the first arriving officer briefly and then returned to his car. Officer Justin Clary arrived and parked on Fessenden, just west of the 7-11, as did the other two North Precinct officers who had joined the search. Officer Clary armed himself with his AR-15 rifle because of the information that they were dealing with an armed suspect. Officer Clary and the other two officers who parked on Fessenden walked east into the 7-11 parking lot to get a view of the car and the inside of the 7-11. In the meantime, the North Precinct sergeant who had joined the search had also arrived and parked to the east of the 7-11, near the Shell gas pumps.

The two males that the first arriving officer had seen previously then exited the 7-11 and headed towards the suspect vehicle. Officer Clary and the two officers walking with him from Fessenden immediately challenged the males with verbal commands to stop and put their hands up. The passenger turned and started walking away from the vehicle and stopped. The driver, Billy Wayne Simms, continued walking to the vehicle, got in, and started the engine. When Mr. Simms started the engine, the officer who had arrived first and was parked in the parking lot drove his car forward to box him in. Mr. Simms drove in reverse towards the officer's car, and then drove forward over the cement parking stops onto the sidewalk of the 7-11. He then turned the car northbound and continued driving.

Officer Clary was continuing to shout commands from the position in the 7-11 parking lot he had walked to while trying to glimpse inside the 7-11. He was north and slightly east of Mr. Simms's car, on the passenger side. Officer Clary watched Mr. Simms through the open front passenger window. Officer Clary observed Mr. Simms making a motion that he interpreted as Mr. Simms digging around under the front seat to find something, while Mr. Simms maintained constant eye contact with Officer Clary. Officer Clary believed Mr. Simms was arming himself. Officer Clary then observed Mr. Simms begin to raise his right arm toward Officer Clary, and believing that Mr. Simms was about to shoot him or another officer, Officer Clary brought his AR-15 up to aim, and fired six times. Officer Clary stated that once he raised the AR-15 to aim it, his ability to see Mr. Simms's hand was limited.

Mr. Simms's car continued northbound after Officer Clary shot, crossing Fessenden and crashing into an apartment building across the street from the 7-11. Officer Clary and the North Precinct sergeant continued across the street to cover the vehicle. As responding officers arrived, a perimeter was established around the block with the apartment building. A second North Precinct sergeant

responded and took command of the incident because the first North Precinct sergeant had been a witness to the shooting. The two North Precinct sergeants discussed the location of the vehicle and the inability to safely obtain a vantage point from which they could ascertain Mr. Simms's condition, including whether Mr. Simms was still in the vehicle or had moved into the apartment. Not knowing if Mr. Simms was still mobile and not seeing a safe way to approach, the two North Precinct sergeants agreed that it was too dangerous for the officers to approach the vehicle, and the second North Precinct sergeant, who had assumed command, requested the Special Emergency Reaction Team (SERT). SERT responded and cleared the vehicle, finding Mr. Simms in the driver's seat, deceased.

When Mr. Simms was removed from the car, a .22 caliber handgun was found tucked in the back of his waistband, missing its magazine.

The post mortem examination found six gunshot entrance wounds that perforated the right lung, the left lung, the diaphragm and the liver, and damaged the pulmonary trunk and ascending aorta. The examiner found that more than one of these gunshot wounds was fatal.

A Multnomah County Grand Jury met on August 9 and 10, 2012, just under two weeks after the incident, and determined that Officer Clary had no criminal liability for Mr. Simms's death.

Timeline of Investigation and Review

7/28/2012	Date of Incident
8/10/2012	Grand Jury concluded
10/31/2012	Internal Affairs Investigation completed
1/24/2013	Training Division Review completed
3/5/2013	Commander's Findings completed
5/10/2013	Police Review Board convened

Analysis/Issues Presented

Tactical Planning

The Training Review evaluated several of the decision points in this incident, noting most were handled appropriately, including:

- North Precinct sergeant's and multiple officers' decisions to join in the search for the vehicle to ensure numerical superiority;
- Officer Clary and the two other officers adapting to the situation and moving to be part of a cover and arrest team after observing the other officers on scene even though there was no articulated plan;
- Attempt by the officers to issue commands and exert control when the suspects exited the 7-11;
- Moving out of the way of Mr. Simms's vehicle as he drove away; and
- Calling SERT when it was concluded that there was no safe approach to Mr. Simms's vehicle.

The Training Review concluded, however, that there was the lack of a plan and leader for the incident, and the location and backstop for the attempt to take Mr. Simms into custody were "least desirable."

The Commander's Review and Findings concurred that the backstop was less than desirable and that Officer Clary's use of deadly force should be found to be in policy, with a debrief on the issue of the backstop. The Commander's Review and Findings also found that the officers should be debriefed on their tactical planning before the incident, and that the conduct of the sergeant who participated in the search for the vehicle should be found to be out of policy for not directing the units while searching for the suspect vehicle and not formulating and communicating a plan to take the suspects into custody.

The Commander's Review and Findings analysis of the tactical planning before the incident provides a sufficient explanation of the analysis of the sergeant's performance to understand fully the basis for finding it out of policy. The Commander quotes from the Training Review analysis that found that, "No one took charge or directed appropriate action." While the officers are looking for the vehicle, "at no time did the primary officer or sergeant suggest what should be done if they found the vehicle. A basic plan articulated over the radio would be more ideal . . .." The Commander explained that the sergeant who participated in the search had clear ownership of the incident not only because he was actively

involved, but also because he was the sergeant assigned to that geographic area of responsibility. The Commander faulted him because rather than taking the opportunity to direct officers on possible tactical solutions, "he allowed the units to think independently and stated 'At that point I was confident that they were able to manage it.'" The Commander found that this omission violated the Bureau's Fundamental Concepts of Tactics: (1) Have a Leader, (2) Have a Plan, (3) Be Adaptable, (4) Don't Assume, (5) Communicate, (6) Correct Mistakes. He concluded that the sergeant "missed the opportunity to direct units during the search of [sic] the suspect vehicle to several possible tactical solutions and, once on scene at the store, to develop a plan and communicate the plan. Sergeant . . . was unable to grasp the situational awareness in order to provide basic direction and defaulted to a 'rapidly evolving event.'"

However, the analysis of the performance of the other officers that merited debriefing is absent. The Training Review pointed out that none of the officers "took charge or directed appropriate action." No one suggested what they should do if they found the vehicle. The Training Review found that not having a plan resulted in two different deployment strategies, with two cars parking out of sight for an invisible deployment and two pulling into the lot to use their cars for cover. The Commander's Review and Findings sets forth the facts regarding the conduct of the officers, but only quotes portions of the Training Review when discussing the sergeant. It does not provide an analysis of the officers' conduct nor a clear, specific statement identifying the portions of their conduct that should have been different. An explicit critique of their performance would improve the value of the findings.

Having a clear statement of the Commander's analysis is especially important because the Police Review Board did not recommend any debrief of the officers on the lack of tactical planning or leadership before the incident. Rather, after a discussion of the issues of lack of planning and the difficulty of planning with so many unknown factors, and after the suggestion of debriefing the officers as a team, the Review Board did not require any debrief on these topics. Instead, the Review Board found that all officers should receive a debrief on the choice of location to initiate contact, specifically referencing that it was in front of a store front during business hours.

The Review Board removed the recommendation for a debrief of Officer Clary on the issue of the backstop on his use of deadly force, because they found he was aware of and took the backstop into account.

The Review Board did find the sergeant's conduct was out of policy on the operational planning and supervision and recommended that he receive command counseling.

The Police Review Board's Findings and Recommendations memorandum, provides a summary of the discussion and some clues about possible reasons, but it does not clearly set forth why the Review Board limited the areas for the debrief of the officers from the broader issues raised in the Training Review to merely the location of the contact and backstop. While this was a fluid, rapidly evolving situation, the officers did miss opportunities during the search for the vehicle to establish a leader, to develop at least a tentative plan of action, and to better communicate with each other.

Recommendation 14: The Commander's Review and Findings and Police Review Board should clearly explain the bases for their conclusions, and where a debrief is suggested on tactical concerns, should ensure that all potential areas are covered.

Decision to Deploy AR-15

The Training Review did not evaluate whether Officer Clary's decision to arm himself with the AR-15 was an appropriate choice in this scenario, or whether, once armed with the AR-15, it was appropriate to approach and challenge the suspects or whether he instead should have moved to cover. Given that the choice potentially limited his options, it would have been appropriate for the Training Review to include this in its decision point analysis.

When choosing a weapon, officers have to balance various pros and cons. At least one officer on scene believed that if a suspect is armed, the responding officers are always required to have a shotgun or AR-15 deployed. Bureau policy or training, however, does not mandate this. A Training Review of this decision could have benefited Bureau officers with a better understanding of the factors to consider in deciding whether to deploy an AR-15. More importantly, the fact that a responding officer misunderstood the expectations of the Bureau regarding deployment of an AR-15 suggests that Training should have evaluated whether this points to a need to re-train this officer in particular or a broader need for a Bureau-wide briefing or training.

Recommendation 15: Whenever an officer makes a choice between weapons to deploy, the Training Review should include analysis of that choice.

Recommendation 16: Whenever an investigation into a critical incident reveals that a Bureau member is not fully aware of policy or training doctrine, Training should evaluate whether that officer's misunderstanding signals a broader need for a Bureau-wide briefing or training.

Decision to Block in Suspects' Car

The first officer on scene articulated clearly his reasons for blocking in Mr. Simms's car – he is concerned that any danger from confronting Mr. Simms at this location is much less than the danger of allowing him to leave the location and engage in a subsequent pursuit. A number of the officers echoed these concerns about allowing Mr. Simms to drive away, specifically mentioning the erratic driving already reported about this vehicle. Blocking a vehicle, however, is inherently dangerous. In this situation it was made more dangerous by the location in front of an open business and the belief that there was an armed suspect in the car.

The Training Review, however, does not identify this important decision point in its analysis. The Bureau, and specifically the involved officers and supervisors could benefit from a training analysis of this decision that explains the factors to be considered in such a decision.

Training to Deploy Ballistic Shield

Both North Precinct sergeants who were on scene – both of whom had recently transferred to patrol assignments – stated they had never been trained in the use of the ballistic shield and that their lack of comfort with the shield and whether it could effectively protect officers contributed to their decision not to approach Mr. Simms's car or the apartment and to instead ask SERT to respond to perform these tasks. The Commander's Review and Findings noted that the Bureau needs to develop a protocol to ensure that supervisors have all appropriate training when they transfer positions. The Police Review Board Findings and Recommendations memorandum recommends that the Bureau develop such a protocol. We concur.

Critical Incident Management Course for Supervisors

The Commander's Review and Findings noted that neither North Precinct sergeant who was on scene had attended the Critical Incident Management course before transferring to patrol supervision responsibilities. The Commander recommended that Bureau review personnel as they transfer to new assignments to make sure they have the requisite training. The Police Review Board Findings and Recommendations memorandum recommends that the Bureau develop such a protocol. We concur.

Recommendation 17: The Bureau should review training for supervisors periodically, and when they transfer substantive assignments should ensure they have received all relevant training.

Quality of Investigation and Review

Internal Affairs Interview of Involved Officer

Officer Clary declined to provide an on-scene walk through or statement to Detectives on the date of the incident. He provided a statement to Internal Affairs investigators four days later on August 1, 2012. As we have stated repeatedly, this four-day delay is longer than ideal.

Internal Affairs Investigators' Interviews of Officers

The quality of the interviews conducted by the Internal Affairs investigators was, for the most part, good. Substantively they covered the requisite areas thoroughly. However, the interview technique was inconsistent. Most of the time the investigators were very careful to ask appropriate follow up questions. There were times, however, when they missed follow up questions and left ambiguities. In most of the interviews, the investigators' questions were simple and open, but on too many occasions, the investigators fell into the trap of asking overly complicated, compound questions where the investigators recited the facts as they understood them from other parts of the investigation, instead of allowing the interviewees to first provide the facts.

There was one point in his interview where the sergeant was part way through telling his recollection of the events when he was asked a very specific question about whether something happened immediately after the shooting. Instead of responding to the closed question, he stated to the investigators: "Maybe I should

continue the story." And then continued based on his recollection of what occurred.

There were also a handful of questions where the investigators' questions were leading and appeared to be providing the interviewee with an acceptable, in-policy, explanation for the decision made. To the credit of many of the interviewees, they did not just accept the answers provided them, but tried to honestly answer the questions based on their rationales for making the decisions they made.

It does not appear that the investigators asked the compound, closed, and sometimes leading questions for any improper purpose. Further, it is clear from all the interviews that these investigators do know how to properly formulate their questions. Therefore, it would be beneficial for them to receive feedback from their supervisors and to self-critique their questioning technique to help them be more vigilant to avoid this in the future.

One other issue that arose in the interviews was that the Internal Affairs investigators repeatedly ask the involved officers what their "probable cause" was for stopping Mr. Simms. One officer appropriately corrected them in his answer describing his "reasonable suspicion." While this is a minor point, it is important that investigators use the proper terms because officers may mistakenly infer from a question about probable cause that they needed probable cause and then either feel pressure to overstate their suspicion, or be wrongly concerned they violated policy.

Recommendation 18: Internal Affairs supervisors, the Police Review Board, and anyone else reviewing the investigation should be vigilant in reviewing interviews not just to ensure coverage of all relevant subjects but also to monitor the form of the questions asked and to remind investigators to avoid compound, closed, and leading questions.

Timeliness of Training Review

The Training Division Review in this case was not completed until three months after completion of the Internal Affairs investigation. As we stated above, there were transitions of personnel that may have led to the confusion and issues with the assignment and completion of the Training Review. If issues still exist in the assignment and completion of the Training Review, the Bureau should address these.

Issues Raised by Involved Personnel

During the interviews by Internal Affairs and in after action reports, participants in the incident raised several systemic concerns. It is commendable that the investigators and Bureau procedures allow opportunities for participants to provide their input. With one exception, however, there is no indication whether the Review Board or another mechanism within the Bureau evaluated those concerns or implemented remedies when appropriate.

In his after action report, the North Precinct sergeant who took command of the incident after the shooting noted that the second suspect had been placed in a patrol car after he was arrested, but then that patrol car was used as cover for officers watching Mr. Simms's car. He noted that this suspect should have been moved to a safer location. This appears to be an appropriate topic for a debrief of the participants, however, there is no indication any of the officers received a debrief on this subject.

This sergeant further noted that the command post was difficult to reach for responding units and that the directions to reach it were confusing. This caused interruptions in his efforts to fulfill his responsibilities after the shooting because he and other officers on scene were distracted by the need to respond to requests to clarify how to reach the command post. He indicated this hindered his performance.

In his interview, the North Precinct sergeant who arrived first and was present for the shooting raised concerns about the difficulty of obtaining information from the Mobile Data Computer about the prior, related incidents in the East Precinct for which they were searching for Mr. Simms.

In another interview, one of the involved officers mentioned that a high level City official had come to the scene and was within the crime scene taking pictures. The officer felt there needed to be proper protocols for ensuring the integrity of the crime scene and that only appropriate personnel enter and document it.

In the Commander's Review and Findings, the Commander raised concerns, as mentioned above, about the lack of training of supervisors in critical incident management and in the use of ballistic shields, and the need for the Bureau to better ensure all supervisors have appropriate training. The North Precinct sergeant who took command after the incident mentioned in his interview that he

had not dealt with a situation like this recently and so as he was running the post-incident response, he was feeling "rusty."

All of these are valid critiques and concerns worthy, at least, of further discussion. Except for the issues of reviewing training when personnel are moved to new assignments, there is no indication that the Bureau or the Police Review Board addressed any of them.

Recommendation 19: The Bureau should develop some mechanism to ensure that any systemic concern raised by a participant during the investigation or in after action reports is evaluated to determine whether or how to address it.

Surveillance Video of Shooting

As mentioned above in the discussion of Moffett, best investigative practices dictate that in order to obtain a pure statement of the officer's state of mind and his or her own memory, it is imperative that officers provide a statement prior to watching any surveillance video. In this case, consistent with those practices, Officer Clary was not shown the video from the 7-11 surveillance cameras until after he had provided his independent recollection. In addition, investigators handled the video issue very well. They showed it to the officer in a non-confrontational way, allowing Officer Clary to offer comments, but not forcing him to feel defensive about differences. There were a few points in Officer Clary's recollection that differed from the video, including how far south he had moved in the parking lot and where the car was relative to the windows of the 7-11 when he fired. When asked about the car being in front of the 7-11 windows when he fired, he simply explained that he thought he had described his perception as best he could. The video also jogged Officer Clary's memory that he had considered the AR-15 to be a superior weapon in that situation because it minimized potential risk of over-penetration and striking the backdrop. The Internal Affairs investigators should be commended for using the video responsibly, promoting a culture that allows officers to feel confident in explaining their perception, and not fueling the fears that video will be used for "gotcha" games.

August 21, 2012 ◦ Michael Tate

Portland Police detective Travis Fields was assigned to the U.S. Marshals Service Fugitive Apprehension Task Force where he served with members of other law enforcement agencies with the goal of locating and apprehending high risk violent offenders throughout the state. Michael Tate was the subject of an arrest warrant for felony domestic violence related offenses in Beaverton, as well as a warrant for probation violation. Following the domestic violence incident, he had cut off his GPS monitoring anklet that he was required to wear as a condition of his probation.

Detective Fields was working with a Washington County Sheriff's Office detective, who was the primary case officer assigned to Mr. Tate's apprehension. The Sheriff's detective had developed information that Tate may be staying in an apartment in Aloha, in Washington County, that had at one time been rented to Tate's aunt. A total of six officers watched the apartment for several hours to see if they could spot Mr. Tate through a window, or perhaps coming out or going in, but only could see a single female occupant moving about the apartment. Rather than continue to expend resources watching the apartment based on what seemed to be speculative information, Detective Fields and the Sheriff's detective decided to go knock on the door.

They opted for a low key approach with just two officers, because they needed the occupant's consent to enter the residence[18] and a show of great police force can be intimidating and negate consent. The officers discussed, via radio from their various positions around the apartment building, plans for various contingencies, the most likely of which was that the female occupant would not let them in but may give them some indication through her body language or other response whether she had any connection to Mr. Tate. In that event, the detectives' plan was for one of them to drive away while the others continued to watch the location for additional movement. Getting the female occupant's consent to their entry and then finding Mr. Tate in the apartment was not considered to be a likely scenario. Nonetheless, when they knocked on the door, a woman answered and when they asked if Michael Tate was there, she let them in and indicated he was in the living room.

[18] Though they had an arrest warrant for Mr. Tate, they would have needed a warrant to enter the apartment absent consent, because the apartment was not Mr. Tate's primary residence.

Mr. Tate was sitting on the couch and Detective Fields interpreted his demeanor to indicate that he was just going to give up. He stood up when the detectives asked him to, and then turned as though he was cooperating with being handcuffed. But then he spun to the opposite side of the couch and, according to Detective Fields, began digging in his pocket as he looked over his shoulder at the Sheriff's detective. Detective Fields then saw him pull a black object out of his pocket and yelled, "gun." He believed Mr. Tate was holding a small caliber handgun, though he could see just a small portion of something black protruding from Tate's hand. He then recalled seeing Mr. Tate raise the object up toward his eye as if he were lining up sights, acquiring a target, and turned his hand sideways, as if he were going to shoot in what he described as "gangster style." Detective Fields fired his weapon two times, missing both. Mr. Tate fled through the third-story apartment and jumped out the bedroom window. Though he was not struck by either of Detective Fields' bullets, he suffered significant injuries from the fall. Detectives staged outside quickly secured Mr. Tate and summoned medical personnel, who arrived promptly and transported him to the hospital.

Detectives found a black cell phone near where Mr. Tate had fallen. They searched the apartment but did not find a gun.

Investigators located both of Detective Fields' spent rounds. The first bullet passed through the dining room wall and into the adjacent apartment, through the dining area of that apartment, out the window and into an exterior balcony wall. No one in that apartment was impacted. The second bullet lodged in a wall of the apartment where they located Mr. Tate, near the doorway into the kitchen. The female occupant was in the kitchen at the time of the shooting.

The woman who lived in the apartment was Tate's cousin. She spoke with Sheriff's Department detectives as well as Bureau Internal Affairs investigators. She reported that Mr. Tate had arrived at her apartment earlier that day, upset and crying. He told her he had been in a fight with someone and then cut off his ankle bracelet because he did not want to go back to prison. He said that if police came looking for him he was going to act like he had a gun so they would shoot him because he wanted to die. She said he did not have a gun. She was getting ready for work when detectives knocked on her door, and said when interviewed that she had planned to call police when she got to work and tell them that Mr. Tate was in her apartment. She was in the kitchen when detectives confronted Tate in the living room. She heard a scuffle followed by gunshots but did not witness the shooting.

The Washington County District Attorney's office reviewed the investigation and determined there was no evidence of any criminal wrongdoing by Detective Fields and therefore no need to present evidence to a grand jury. The Bureau concluded the use of deadly force was within policy.

Timeline of Investigation and Review

8/21/2012	Date of Incident
10/17/2012	Washington County Sheriff's Office Detectives' Investigation completed
12/19/2012	Internal Affairs Investigation completed
1/29/2013	Training Division Review completed
3/22/2013	Commander's Findings completed
5/15/2013	Police Review Board convened

Analysis/Issues Presented

Tactical Planning

The detectives charged with apprehending Mr. Tate did not expect to gain consent to enter the apartment and actually find Mr. Tate there. Detective Fields described this as a very unusual experience and Mr. Tate's cousin's casual attitude about letting them in the door as surprising. The team of detectives had contingency plans for other, more likely scenarios, but no plan for how they would take Mr. Tate into custody if they found him in the apartment. Despite the fact that the mission of the task force is to locate and apprehend high risk violent offenders, Detective Fields stated they believed that Mr. Tate would just go with them willingly once they found him. Both Detective Fields and his Sheriff's Department partner said the low-key approach they employed with Mr. Tate often worked in getting suspects to accede to handcuffing and arrest. The cooperation and nonchalant attitude of Mr. Tate's cousin when she answered the door coupled with Mr. Tate's initial compliance and apparent calm confirmed this belief and further lulled them into thinking they could apprehend Mr. Tate without incident.

The Commander who reviewed this investigation and prepared the Commander's Review and Findings in this case recognized the dangers of this laid-back approach to arresting a high risk offender and did an excellent job of analyzing and evaluating the evidence he had and identifying ways that the detectives could have improved their performance to create a better outcome. For example, rather than just walking past Tate's cousin when she waved them into the apartment, they could have questioned her about weapons or Mr. Tate's state of mind, and perhaps elicited the information she later shared about Tate's plan to provoke officers into shooting him. The Commander also noted that the detectives could have used a greater degree of command presence when approaching Mr. Tate, physically putting hands on him to gain control rather than simply asking him to comply and giving him the opportunity to flee.

One issue not addressed by either Training or the Commander is the location of Mr. Tate's cousin. The detectives were not aware of her whereabouts and did not direct her to any location until after the shooting. For her safety and the safety of the officers, a better practice would have been to ask her to exit the apartment and to direct officers outside to approach and keep her secure while the detectives apprehended Mr. Tate.

Threat Recognition and Backdrop

Detective Fields described in great detail Mr. Tate's hand movements and his own thought process for identifying and responding to the perceived threat. As we have often heard officers describe when recounting their involvement in a shooting, Detective Fields said everything slowed down for him. He remembered thinking that he wanted to be able to positively identify the black object in Mr. Tate's hand as a gun, but could just see a small portion of it. When Mr. Tate raised the object to his eye level, Detective Fields recalled thinking that it would not make sense for a person to do that with any object other than a gun when confronting police officers who want to arrest him. That motion by Mr. Tate is what prompted the detective to fire his weapon, and was consistent with the statements Mr. Tate made to his cousin earlier that day about his intent to provoke officers into shooting him.

Detective Fields described the backdrop for this shooting as an exterior wall that faced an open field, for the first round, and the apartment's kitchen and possibly the refrigerator, for the second round. That was a misperception, as in reality his first round passed through a wall and into and through the adjoining apartment. The second round entered the wall near the doorway to the kitchen. Fortunately,

no one was present in the adjacent apartment at the time of the shooting, and no bullets impacted Mr. Tate's cousin, who was in the kitchen. Detective Fields' perception of his backdrop was addressed by the Commander is his findings memo, and his misjudgment is worth noting. However, as the Commander further noted, a poor backdrop should not preclude an officer from using deadly force when confronted with a serious or deadly threat.

Quality of Investigation and Review

Sheriff's Department Detectives Completed Criminal Investigation

A Memorandum of Understanding between the Police Bureau and the U.S. Marshals Service establishes the terms of Bureau detectives' participation in the Fugitive Apprehension Task Force. It provides that members shall comply with their own agency's use of force policies and, in the event of a shooting, the incident be investigated by the responsible agency in the jurisdiction of the shooting. In this case, the appropriate investigating body was the Washington County Sheriff's Office Major Crimes Team. Bureau officials were notified of the shooting and responded to the scene, but otherwise stood down as the Sheriff's Department completed a criminal investigation of the shooting and presented the evidence to the Washington County District Attorney.

The criminal investigation generally meets basic standards – the scene was thoroughly processed, searched, and documented; civilian witnesses were interviewed, including Mr. Tate's family members who might have knowledge of his mental state; evidence was handled properly; and investigators completed a thorough interview of Detective Fields.[19] One very significant shortcoming of the Sheriff's Department investigation, however, was the failure to interview the Sheriff's detective present at the time of shooting. He produced a written report at the time of the incident, but was asked to answer questions about his actions

[19] Pursuant to Bureau protocol, the Bureau Internal Affairs Captain served Detective Fields on the day of the shooting with a notice to appear for a compelled interview 48 hours later. Internal Affairs rescinded that notice when Detective Fields consented to a voluntary interview with a Sheriff's detective and a Beaverton Police Department detective that was conducted two days after the shooting.

and observations only when interviewed by the Bureau's Internal Affairs investigators, four months later.[20]

One other, less significant, way we found the Sheriff's Department investigation to be below the standard we have come to expect of the Bureau Detectives Division is in the lack of transcriptions of the interviews with Mr. Tate's cousin or of Sheriff's Department contacts with Mr. Tate. Those contacts were recorded, but as we and other consultants have noted in the past, a transcription increases the likelihood that those responsible for a Department's executive-level review will thoroughly review all the relevant materials without relying on investigator's synopses.

Police Bureau Internal Affairs Investigation

The Bureau's Internal Affairs investigation was largely thorough and complete. It pulled together all the materials collected in the Sheriff's Department investigation, and filled the significant gap in that case by including an interview of the Sheriff's detective who led the task force team responsible for apprehending Mr. Tate and was present in the apartment during the officer-involved shooting. This interview was conducted by telephone, which we have noted in the past to be less than ideal. Here, however, the investigator articulated his reasons for doing a telephonic interview as his belief that an in-person interview would not have resulted in any more detailed information, particularly given that he did not need to reference diagrams or other visual cues in his questions. In addition, he noted the time pressure he was under to finish his report was a factor in his decision. In this articulation, the investigator implicitly acknowledges that in-person interviews are generally preferable, and we do not disagree.

Internal Affairs investigators did not attempt to interview Mr. Tate because he was represented by counsel and remained in Washington County jail awaiting trial. Mr. Tate had been largely uncooperative with Sheriff's detectives. We appreciate the investigator's justification for not attempting to speak with Mr. Tate, as well as his thorough documentation of his reasoning, but nonetheless believe an attempt to interview Mr. Tate could have been worthwhile. By the time of the investigation, significant time had passed since Mr. Tate's arrest. In

[20] A police report can never substitute for a full blown interview that allows for follow up questions and in which the area of inquiry is dictated by the investigator, not the report writer.

addition, Mr. Tate might have appreciated the difference between an Internal Affairs investigator from an agency outside the jurisdiction in which he had been arrested and a Major Crimes detective from the county in which he was incarcerated. Particularly given the extent to which the Bureau's understanding of how and why Detective Fields' formed the impression that a cell phone was a handgun hinged on Mr. Tate's statements to his cousin about wanting to provoke police to shoot him, an interview of Tate could have been particularly valuable. Ideally, investigators should have attempted to make this contact through Mr. Tate's attorney and documented any refusal to participate.

Thorough Review by Bureau Commander

The Commander's findings memorandum in this case was particularly detailed, thorough, and well-reasoned. While ultimately concluding that Detective Fields' use of deadly force and surrounding actions were not out of policy, the memorandum expresses concerns about the operational planning, some aspects of the detective's performance, as well as the supervision and operation of the Task Force in general. In particular, the memorandum discusses:

- Lack of specific planning for the possibility that Mr. Tate might be in the apartment.
- Failure to attempt to gather information regarding guns or Mr. Tate from Mr. Tate's cousin as the detectives entered the apartment.
- Failure to immediately assert physical control over Mr. Tate upon entry into the living room.
- Detective Fields' backdrop for shooting.
- Need for greater level of field supervision for U.S. Marshal's Fugitive Task Force.

The Commander addressed these issues in a documented debrief of Detective Fields after the Review Board meeting.

Training Division Review

The Training Division Review was not as rigorous as the Commander's findings memo. In an analysis that was shorter than the Division's typical reviews, Training found all aspects of this incident – planning, making contact, use of deadly force, and post-shooting processes – to be "desirable," meaning that the "actions demonstrate sound and effective tactics." The review did not address Detective Fields' backdrop or the presence of the cousin inside the apartment at

the time of the shooting, and did not acknowledge or discuss the tactical deficiencies noted by the Commander.

September 29, 2012 ◦ Joshua Baker

On the date of the incident, East Precinct officers responded to a call for a welfare check from a woman who indicated that she and her boyfriend, identified as Joshua Baker, had gotten into an argument and that after she left their apartment she had heard a gunshot. As officers began to arrive and stage outside the apartment, the woman, who was still in the apartment building, additionally reported that she had heard a second gunshot. Shortly thereafter, dispatch received a 911 call from an unidentified male indicating that he was armed with a .22 caliber rifle and that he was "homicidal" and "suicidal." Communications was able to trace this call to the same apartment building.

The woman subsequently reported that she observed Mr. Baker leave the apartment building carrying a rifle and enter his truck. Officers observed a vehicle matching the description provided by the woman and began to follow the truck. As they were following the truck, additional information was received and broadcast to responding units that a man had been shot in the chest in the same apartment building. At that time the on-scene sergeant in charge decided that he would conduct a high risk felony stop on the vehicle and prepared to tactically engage the suspect with other officers following behind. The vehicle momentarily stopped but then sped away at a high rate of speed. The sergeant allowed marked units to pass him as the lead cars in the subsequent vehicle pursuit while he visually monitored the chase. Officer Gary Britt drove the lead vehicle in the pursuit, and was accompanied by his partner, Officer Eric Strohmeyer.

During the pursuit, speeds reached an estimated 90 miles per hour with Mr. Baker speeding through several red lights, and at some point officers lost sight of the truck. As Officers Strohmeyer and Britt attempted to locate the vehicle, they began to enter a "T" intersection when they observed the vehicle they had been pursuing had apparently crashed into a fence. Immediately thereafter, the officers saw Mr. Baker get out of the truck in front of them carrying a rifle. Without having time to exit their patrol car, Officer Britt then fired 10 rounds from his handgun while Officer Strohmeyer fired 7 rounds from his AR-15 rifle that he had already been holding during the pursuit. Mr. Baker fell to the ground in a seated position with the rifle nearby. The involved officers reported that they believed the suspect had been struck by their gunfire.

As other officers and the sergeant arrived, responding officers instructed Mr. Baker to move away from the rifle so that they could have paramedics treat his

injuries. Baker declined to cooperate. Instead, he sat by the car sending text messages from his cell phone and at one point climbed into his truck and turned on the radio. The sergeant requested that the Special Emergency Reaction Team (SERT) be activated, and that team arrived approximately one hour after they were contacted and took Mr. Baker into custody without further incident. Mr. Baker was transported to the hospital where he was treated for the serious but non-life threatening head injury that he suffered as a result of being struck by one of the rounds fired by the officers. A further investigation revealed that Mr. Baker had in fact shot an individual at the apartment building and he was charged with attempted murder.

Mr. Baker was interviewed about the incident and indicated that he had grabbed his rifle immediately after crashing his vehicle and had hoped that the police would shoot him as a result of his actions. While Mr. Baker admitted that the rifle was pointing towards the street, he indicated that he had no intention of shooting the police and would not have had the capability of doing so because the rifle was in a protective sock that would have prevented him from operating the trigger mechanism. Mr. Baker's rifle was operational and loaded with ammunition, but covered with a protective sock.

The Bureau found the use of deadly force by the officers and the preceding vehicle pursuit were within policy.

Timeline of Investigation and Review

9/29/2012	Date of Incident
11/19/2012	Internal Affairs investigation completed
1/29/2013	Training Division Review completed
3/6/2013	Commander's Findings completed
5/15/2013	Police Review Board convened

Analysis/Issues Presented

Tactical Issues Not Addressed

The Training Division Review in this case is entirely complimentary and contains no criticism or reflection on how officer or supervisory decision-making might have been better. We agree that much of the tactical decision making and performance here was exemplary:

- Careful staging of the responding officers,
- Sergeant's instruction at the initial staging point to ensure that the responding officers were behind cover,
- Decision whether and when to conduct a high risk stop,
- Sergeant's decision to allow marked units to be lead in the pursuit,
- Sergeant's request for spike strips with the caution to keep distance because the suspect was armed,
- Sergeant's request to evacuate houses behind the truck.

Nonetheless, it is the rare deadly force incident that does not allow for helpful critique and introspection, regardless of whether the decision to use deadly force was within policy. In this case, the following issues could have been identified and more fully addressed during the Bureau's analytical review:

- **The decision by the sergeant to be involved in the high risk felony stop.** The Training analysis appropriately commends the sergeant for his decision to allow marked units to lead the pursuit once Mr. Baker drove away at a high rate of speed. Bureau tactics and policy prefer that marked units are tactically involved in vehicle pursuits and that any on-scene supervisor follows to manage the pursuit. However, prior to that, as Baker pulled out of the parking lot, the sergeant was the first to follow. While other marked units came behind him, the sergeant was involved in trying to confirm the license number and was the first to initiate the high risk felony stop. The Training analysis does not discuss whether it would have been preferable for the sergeant to have assigned these tasks to other officers on scene and for him to supervise and manage them, as he did when the incident transitioned to a vehicle pursuit.
- **The initial encounter in the intersection with Mr. Baker and the involved officers.** As indicated above, when the officers entered the intersection, they immediately saw the crashed vehicle and observed Mr. Baker come out of it with a firearm. From their narrative, it appears that

the immediacy of the threat presented caused them to believe that they needed to respond with deadly force. However, neither the Detectives nor Internal Affairs interviewers directly asked the officers whether they could have taken other action, such as tactically repositioning. Nor were the officers directly asked whether their speed while looking for the suspect caused them to end up too close to the crashed vehicle. Ultimately, the Bureau could well have concluded that the officers had no viable options other than the use of deadly force. However, fully probing the officers' states of mind by asking such questions and considering potential options would have produced a more robust and critical analysis of the incident.

- **The sergeant's entry into the intersection.** The sergeant indicated that he came upon the crash scene within moments after the use of deadly force. Responding officers stated they were concerned about the fact the sergeant stopped his car past their positions and too close to the suspect, who they still considered a threat, so much so that they asked the sergeant to back up and/or reposition to where they were. However, the Training analysis neither discusses nor critiques this issue.[21]
- **The decision by the sergeant to keep the shooter officers in lead tactical positions.** While officers waited for SERT to arrive to take Mr. Baker into custody, the sergeant decided to keep Officers Strohmeyer and Britt engaged in the incident, with Officer Strohmeyer designated to use lethal force and Officer Britt designated as the less lethal officer. He stated he did so because Strohmeyer was armed with the AR-15 and well-equipped should the suspect attempt to re-arm himself and aggress the officers. Investigators learned that the sergeant told the officers he was not going to pull them out and instead instructed them to "stay in the fight" since they were in "combat mode." According to the officers' interviews, they remained on point until the SERT team arrived, approximately one hour later.

  The sergeant's decision to keep the shooter officers engaged as cover officers was certainly worthy of discussion, analysis, and critique. Officer-involved shooting protocols instruct field supervisors to pull shooter officers out of tactical or other responsibilities as soon as possible, in large part because of concern about their emotional state in having perceived a deadly threat and their subsequent use of deadly force. When

[21] There was additional discussion in the interviews whether the sergeant had worn out his brakes during the pursuit as a potential explanation for his positioning in the intersection, but this was not fully assessed by Bureau experts or command staff.

interviewed, both officers admitted to perception and memory deficits as they used deadly force with regard to which officer fired first or how many rounds they fired. While the fact that Officer Strohmeyer was AR-15 certified and equipped could have been of some consequence to the sergeant's initial designation decisions, the report indicates that soon thereafter at least one other non-involved officer arrived on scene with an AR-15 and there is no apparent reason that he could not have then assumed the lethal force designation role.

Recommendation 20: The Bureau should provide a focused briefing to all supervisors reminding them of the Bureau's expectations and training regarding the advisability of assigning involved officers to tactical roles after a shooting incident.

Quality of Investigation and Review

Timely Completion

The six month time frame for completing the investigation and review of this incident was much improved from other shootings we have reviewed. Moreover, internal communications indicated a greater interest and dedication among both internal and external stakeholders in moving the process forward. For example, there are communications from both the Captain of Internal Affairs and the Independent Police Review Director noting that the Training Review was overdue and requesting the Training Division to complete its work. The fact that this investigation and review was completed within a reasonable time frame is the best indication that a determined Bureau can finish a thorough review process in a timely way.

Delay in Interviewing Involved Officers

The two involved officers were interviewed by detectives four and five days after the incident respectively. This delay in interviewing the officers runs contrary to investigative practices and leaves the Bureau without any information about the shooting incident from those most knowledgeable about the incident for days. We have repeatedly emphasized the importance of the Bureau obtaining interviews from involved officers before the end of their shifts, and again urge the Bureau to work to create protocols ensuring that it does so.

Commander Critiquing His Own Performance

The Commander's Review and Findings discusses the after incident decision making and praises the Bureau response. However, the Commander notes that he arrived on scene after the incident and made some of the operational decisions that he then assessed in the Memorandum, including taking control of the arriving SERT units and providing them instruction on how to separate the suspect from the rifle. Where a Commander played an operational and decisional role, that same Commander should not then assess the incident. Clearly, that review and critique should be made by a supervisor not involved in those on-scene decisions, perhaps the Commander's supervisor.

Recommendation 21: The Bureau should devise protocols instructing Commanders to defer to their supervisors any post-incident officer-involved shooting assessment in which they were operationally involved.

Failure to Use Visual Aids or Diagrams During Interview

In the cases we evaluate in this report, we have generally been impressed with the Bureau's use of diagrams or other visual aids to provide documentation of positioning or placement of individuals or other objects related to the incident. However, in this case, during one interview an involved officer was asked where the suspect fell in relation to the truck. In response, the officer said that if he had a picture he could show the interviewer where the suspect had fallen. Unfortunately, the investigator did not then provide a picture or utilize a diagram to aid in the officer's description.

Missed Opportunity to Assess Operability of Firearm

As noted above, the rifle retrieved from the crime scene that had been held by Mr. Baker was enveloped by a sock-like material. The officers who used deadly force indicated that they were not aware of the covering until after they used deadly force and Mr. Baker fell to the ground. The Commander's Review and Findings discusses this fact and discounts its importance, opining that the rifle could still likely have been successfully fired even with the covering intact. As noted above, in his interview, Mr. Baker disputed this and asserted that he would not have been able to fire the rifle with the sock covering over it.

The Bureau could have definitively resolved this dispute by testing the rifle's ability to be readily fired with a sock covering. This analysis was likely

inconsequential in assessing the threat initially perceived by the shooting officers since they said they did not notice the rifle was covered until after they had fired. Nonetheless, on a going forward basis, such a review could have provided helpful learning about the degree of threat a rifle covered with such material presents responding officers. Most importantly, instead of relying on the Bureau Commander's speculation about the operability of the rifle, an objective test by the Bureau's weapon experts could have either confirmed or refuted Mr. Baker's assertion.

Sergeant Questioning Efficacy of Ballistic Shield

Very soon after the 2010 shooting of Aaron Campbell, and in response to concerns about delays in providing medical treatment to injured subjects, the Bureau equipped all sergeants' cars with ballistic shields to allow officers to safely approach and take into custody injured subjects who may be armed. In this case, the sergeant had a ballistic shield available but he declined to use it because he said to do so would have been too risky, as he opined that the shield would not have adequately protected the officer from a rifle round.

The Bureau did not address this opinion by the sergeant during its analysis. It would have been helpful for the Bureau's experts to address this concern and gauge its legitimacy. If the sergeant is correct, it raises questions about the efficacy of ballistic shields for approaching downed subjects. If he is incorrect, his misperception and unwillingness to deploy the shield points to an inadequacy in the Bureau's training on this issue.

February 17, 2013 ◦ Merle Hatch

Just before 9:30 p.m. on February 17, 2013, East Precinct officers were dispatched to Portland Adventist Hospital in response to a call of a man with a handgun at the hospital who had pointed the gun at a security officer. Dispatch also reported the man was a patient at the hospital and that he currently was in the employee parking lot. Two sergeants were the first to arrive on scene, quickly followed by numerous officers, who locked down the hospital, blocked traffic coming into the area, and began to set up a perimeter around the parking lot, which also was surrounded by a six to eight-foot fence. The sergeants requested an AR-15 rifle operator, a K9 officer, and air support, and asked for Project Respond to be called out.

The subject of the call, later identified as Merle Hatch,[22] was quick to identify the sergeants and gave a "whoop," seemingly to get their attention. One of the sergeants, Nathan Voeller, identified what he believed to be a gun in Mr. Hatch's hand. Over the radio, he advised all responding units that the subject had a gun and instructed officers on the scene to find hard cover. Sergeant Voeller, along with Officers Andrew Hearst and Royce Curtiss, positioned himself at the entrance/exit point of the parking lot, which also was near a door to the hospital. The other sergeant and several other officers were in the same general area, along with a sergeant who was an acting lieutenant on that shift. Most were grouped around two patrol cars as cover. Officer Hearst, who was armed with an AR-15 rifle, and Sergeant Voeller moved up slightly and away from other officers to get a better view of the subject, taking cover behind another car in the parking lot. Mr. Hatch moved around frequently, walking around cars and behind vegetation, in and out of view. The lighting in the parking lot was poor, but officers generally could track Mr. Hatch's movements through some ambient light and the occasional use of a spotlight. Mr. Hatch once approached a car that was pulling out of the lot,[23] but the car pulled away without incident.

Mr. Hatch then climbed atop an SUV near the parking lot fence, approximately 300 feet away from the officers' position. Officers reported concern and surprise that Mr. Hatch did not use the vehicle as a means to climb over the fence and

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[22] The hospital staff member who called 911 gave officers a different name, because Mr. Hatch had provided a different name when he registered with hospital intake.

[23] This individual apparently had already been in the parking lot at the time the hospital was locked down.

escape. Instead it appeared as though he was using the SUV to gain a higher vantage point in an effort to spot officers' positions. Officers reported seeing what they believed to be a gun in Mr. Hatch's hand, and some reported seeing him raise it, seeming to point it in the officers' direction. Mr. Hatch was yelling throughout this incident, though officers could not understand what he was saying. In a cellphone video taken by a bystander who was closer to Mr. Hatch, but on the other side of the fence, Mr. Hatch can be heard repeatedly telling officers to, "come on play" or "come on in." He said, "Close as you gonna get? That ain't close enough." And, "Do somethin'" and, "you want some?"

Officers held their position at the parking lot opening. Sergeant Voeller was focused on containing and isolating Mr. Hatch, to keep him from getting back into the hospital and to keep others away. His emphasis was on not approaching, antagonizing, or further agitating the subject. Both he and the other sergeant on scene were thinking about calling in the Special Emergency Reaction Team (SERT), but were waiting for the initial activity to settle so they might have time to consult each other as well as the acting lieutenant who had arrived on scene.

A couple of minutes after Mr. Hatch climbed on the hood of the SUV, he got down and began walking toward officers. On the video, you can hear him, seemingly frustrated that officers have not approached him, say, "I'm coming to you then, pig. Let's go. Let's go." The officers only heard generalized shouting, but could not understand what he was saying. Officers reported that he walked purposefully toward them, weaving in between cars, with what they still believed to be a gun in his hand. As he got closer to officers, he began to jog, and then run. An officer yelled, "stop," and "hands up." Officers then heard Mr. Hatch shout, "one, two, three," and then something like, "fuck it all." Officers consistently reported that he was charging their position with what they believed to be the gun raised. When Mr. Hatch was 50-60 feet away from Sergeant Voeller and Officer Hearst's position, Sergeant Voeller fired 10 rounds from his 9mm handgun while Officer Hearst simultaneously fired his AR-15 rifle five times. At the same time, Officer Curtiss also fired three rounds from his 9mm. The three officers described seeing Mr. Hatch stop running, and then drop to the ground. Immediately after that, Officer Curtiss fired one additional round because he believed he saw Mr. Hatch move again, with the gun still in his hand. Six bullets struck Mr. Hatch, all 9mm rounds. The shooting occurred 12 minutes after officers arrived on scene.

Other officers on scene reported that they believed they would have been justified in firing, but did not, because they were positioned somewhat differently or further away than the officers who did shoot, and because Mr. Hatch went down quickly and there was no need for them to fire.[24]

Officers could see what they believed to be the gun laying near Mr. Hatch. Instead of immediately approaching, the sergeant who had not been involved in the shooting planned to get a ballistic shield and assemble a custody team to approach the subject. A third sergeant, who had arrived just after the shooting with a K9, suggested that they instead send his dog to pull the subject away from the gun and then approach. Following this plan, the sergeant sent the dog, which bit Mr. Hatch on the shoulder and dragged his body several feet. There was no reaction from Mr. Hatch to the dog bite, indicating to officers that he was likely already deceased. They approached and secured him, but opted not to apply handcuffs. A medical team immediately moved in and pronounced Mr. Hatch dead at the scene.

The object that officers believed was a gun was, in fact, a broken black plastic phone handset. This is the same object that Mr. Hatch displayed to one hospital security guard, and pointed at another, prompting the initial 911 call. He went to the hospital seeking treatment for hallucinations and anxiety and had been placed in a locked psychiatric unit pending further evaluation. He escaped from that area of the hospital by telling the security officer he had a gun, lifting his shirt and placing his hand on a dark object sticking out of his waistband, and threatening to shoot her. She walked him out of the hospital while giving another employee a code she intended as a warning that the subject had a gun. Once at the exit, he took off through the parking lot and, when he saw another security officer patrolling in a vehicle, he pulled the black object and pointed it at him, prompting him to report that the subject had a gun.

Investigators later learned that Mr. Hatch had been in federal custody four days prior to the shooting. He was supposed to report to a halfway house but did not check in, prompting federal officials to issue a fugitive warrant for escape. Between that escape and the officer-involved shooting, Mr. Hatch allegedly robbed two banks.

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[24] Given the number of "contagious fire" scenarios we have seen in our work with a variety of different agencies, the restraint shown by these other officers is a testament to the Bureau's training to prevent situations in which officers shoot because they hear the gunfire of other officers and shoot without independently perceiving a justification to do so.

The Multnomah County Grand Jury met roughly two weeks after the shooting and determined the officers had no criminal liability for Mr. Hatch's death. The Bureau found the officers' tactics and use of deadly force to be within policy.

Timeline of Investigation and Review

2/17/2013	Date of Incident
3/6/2013	Grand Jury concluded
4/26/2013	Training Division Review completed
5/23/2013	Internal Affairs Investigation completed
7/18/2013	Commander's Findings completed
8/28/2013	Police Review Board convened

Analysis/Issues Presented

Sergeants' Command of Scene

Two sergeants arrived on the scene at nearly the same time. While they did a number of things well, as acknowledged by both the Training Division and Commander's Reviews – calling for needed resources, communicating with arriving officers to turn off lights and sirens and find cover, locking down the hospital, and providing updates on the subject's location – it was never clearly established which of these two was in charge, or whether the acting lieutenant was taking the lead. When each of the involved and witness officers was asked which sergeant was in command, they gave varying responses. This could have led to a greater degree of confusion had the standoff with Mr. Hatch lasted longer, when sergeants and officers would have been expected to implement a more coordinated plan. As it was, events unfolded so quickly that officers were left to react to Mr. Hatch's movements rather than plan their own.

Likewise, the sergeants' failure to establish clear command could have been detrimental if Mr. Hatch had attempted to run from the parking lot. All on scene

agreed that containing Mr. Hatch was a top priority, but it was not clear who was directing the containment. Instead, officers reacted on their own to do what they thought needed to be done and went to perimeter positions on their own initiative. Because Mr. Hatch did not test the containment by trying to flee, it is impossible to judge whether these independent decisions resulted in as robust a containment as would have been achieved through a clearly communicated plan.

The multiple supervisors on scene believed they were working cohesively, even though they did not communicate with each other on a supervisory level. According to one sergeant, it "felt like we were on the same page." That seemed to be true, but we have seen in other incidents where a lack of communication and coordination between sergeants had undesirable consequences. For example, in the officer-involved shooting of Aaron Campbell in 2010, the involved sergeants' disagreement over tactics and failure to work together created a great deal of confusion among officers. Acknowledging that this incident unfolded more quickly than the one involving Mr. Campbell, it is possible that the perceived cohesiveness between sergeants could have broken down in the absence of effective communication had the incident been more extenuated.

Training's critique of the supervisory issues here was pointed, noting the sergeants' failure to clearly establish a leader and communicate a plan to all officers on scene created identifiable risks. The Commander's memorandum acknowledged and agreed with this critique but found the sergeants' overall performance in this incident to be within policy because any communication failures were attributable to the very dynamic nature of this incident and did not in any way precipitate the use of deadly force. This conclusion employs flawed logic. The dynamic nature of an incident makes a supervisory presence even more important, so that officers understand their roles and can act as a unit as events unfold. Further, the question of whether performance is within policy should not be impacted by the consequences or outcome. Whether officers would have used deadly force even with a greater degree of coordination and communication by the sergeants should not be determinative of whether the sergeants' performance met Bureau standards.

Sergeants in Tactical Roles

The two sergeants in this incident put themselves in tactical positions, despite the presence of numerous other officers on scene. This separated them, hindering their ability to communicate with each other to designate a leader or formulate a plan. As officers assembled and positioned themselves behind cover, Sergeant

Voeller noticed Officer Hearst moving slightly away from the group of officers to a position behind a civilian car from which he could better see Mr. Hatch. Knowing that AR-15 operators are trained to work in tandem with another officer who can act as a "spotter" while the rifleman keeps his eyes trained through the sights of his gun, Sergeant Voeller went with Officer Hearst to act as his partner. Sergeant Voeller then ended up involved as a shooter in the deadly force incident. As the sergeant in command of the scene, it would have been tactically preferable for him to assign another officer to go with Hearst and act as spotter.

Following the shooting, the other sergeant assumed command. He assembled a custody team to approach and secure Mr. Hatch, and assigned himself to a role where he physically secured the subject. Again, as the sergeant in charge, it would have been preferable for this sergeant to assign other officers to the custody team while he supervised the operation rather than going hands-on with the subject.

Neither the Training Division Review nor the Commander's memorandum notes the sergeants' tactical role or critiques the sergeants' performance on this basis.

Post-Shooting Approach and Medical Care

The on-scene sergeants decided to use a K9 to approach and bite Mr. Hatch to drag him away from what they believed to be a gun, resulting in what the Medical Examiner's report describes as "multiple, shallow lacerations and puncture marks . . . in the right upper chest and shoulder area" and a "rather deep, horizontally oriented laceration or sharp force injury." A custody team then used a shield and quickly moved in to secure Mr. Hatch and allow medical personnel to treat him. Though it is standard practice to handcuff suspects even when injured, they did not do so here, because it was clear he was not a threat.

The use of the K9 to pull Mr. Hatch away from the "gun" was considered to be consistent with training and found to be within policy. While officers' desire to move quickly to safely secure Mr. Hatch and get him medical treatment is commendable, we question whether this use of the K9 was necessary. Here, the dog bite injuries to Mr. Hatch were postmortem, as he had died almost immediately from gunshot wounds. Where a subject is down but still alive, however, the additional bite wounds, plus any adverse effects of dragging him across the ground, could be seen as unnecessary, particularly where, as here, there are a large number of officers and a ballistic shield available to assist officers in approaching a subject and separating him from a weapon.

Recommendation 22: The Bureau should evaluate whether it is appropriate to use a K9 to approach and bite an injured subject following an officer-involved shooting.

Quality of Investigation and Review

East County Major Crimes Team

The East County Major Crimes Team participated in the investigation in this case, though Portland detectives acted as the lead officers and did most of the investigative work, which we found to be thorough and complete. In one interview of a witness officer conducted by a detective from another agency, we noted that the Bureau Detective present during the interview stepped in to clarify the officer's positioning and to document the officer's use of a diagram to explain his statements about his position. We have made recommendations in prior reports regarding the use of diagrams in interviews and maintaining a clear record. The Bureau detectives in this case did a good job in their documentation of officers' positions through the use of diagrams, in general, and a particularly good job of ensuring that other officers from outside agencies who were conducting interviews did the same.

Training Division Review

With the exception of its failure to address the tactical roles assumed by both on-scene sergeants, the Training Division Review is thorough and complete. It is critical in a constructive way of the supervisors' failure to clearly establish a leader and communicate a plan to all officers on scene, and recommended that Bureau senior leadership reinforce with line-level supervisors and managers the Bureau's expectations that they take command of critical incidents as early as possible. It is unclear whether or how this recommendation was implemented.

Training also noted that all five of the AR-15 rifle rounds fired missed their mark and, referencing three other shootings where AR-15 operators firing at a moving suspect missed their target, recommended additional training for moving targets be added to the in-service training for AR-15 operators. The Bureau's new training facility gives it the ability to use moving targets on its rifle range, and this change is being incorporated into rifle qualifications beginning in 2016. In addition, all certified rifle operators have transitioned to an illuminate optic system that makes it easier for officers to shoot accurately in low light situations (as presented here) and at moving targets.

Role of Hospital Security

Two hospital security guards played critical roles at the outset of this incident, and held potentially valuable information about the subject. In addition, hospital security had an important role to play in locking down the hospital and ensuring that no one exited into the parking lot where officers were engaging with Mr. Hatch. Had this incident not unfolded and resolved so quickly, the sergeants on scene likely would have wanted to establish direct communication with security officers, both to gain information and to ensure that they were fulfilling their expected roles.

Based on the limited information available, the two guards and the hospital's security team, in general, performed well and met expectations. Part of the Bureau's after-action plan following this shooting ideally should have circled back to hospital security, to commend them for things done well, but also to help them examine their security plans and offer constructive criticism on ways they could improve in future similar incidents.

Recommendation 23: Following incidents that involve outside security personnel, the Bureau should consider ways to engage those security forces in the review process and include them in any after-action plans that impact their roles in such incidents.

March 4, 2013 ◦ Santiago Cisneros

Shortly before 11:00 p.m. on March 4, 2013, North Precinct officers Michele Boer and Bradley Kula drove their separate marked patrol cars to the top floor of a seemingly empty parking structure at NE 7th Avenue and Lloyd – a spot where they and other officers frequently meet to talk and catch up on administrative duties in between calls. They stopped their cars facing opposite directions, with driver's sides adjacent, in a position where they could see the ramp as well as the stairway leading up. Almost immediately after they arrived, a sedan pulled up to the top floor of the structure and stopped a short distance from the officers' cars, in the middle of the lot and not in a designated parking space. The driver, later identified as Santiago Cisneros, turned off his headlights and sat in his car talking on the phone. The officers recognized this as unusual behavior, pulled their cars around to better position themselves relative to Mr. Cisneros' vehicle. Officer Boer pulled straight ahead and stopped slightly in front of and to one side of the vehicle, while Officer Kula did a U-turn and drove up toward the other side of the car, stopping slightly further back from Officer Boer's vehicle. The officers directed their spotlights onto Mr. Cisneros' car.

Mr. Cisneros got out of his car and walked to his trunk, where he withdrew a shotgun. He pointed it first toward Officer Boer and fired, and then turned toward Officer Kula and fired. Both officers moved to positions of cover behind their respective patrol cars, and Officer Boer fired two rounds at Mr. Cisneros while he was still near his car. Officer Kula could see Mr. Cisneros tracking Officer Boer with what he believed at the time was a rifle, and then saw him advance on her patrol car. Officer Boer attempted to maintain cover by dropping to her knees at the side of her car as Mr. Cisneros charged toward the car. He fired two more shotgun rounds at her and ultimately rounded the rear of her patrol car to point the barrel of his gun directly at her from two to three feet away. It is not clear what interrupted his fire – a malfunction, simple hesitation, or perhaps rounds fired by Officer Kula – but Officer Boer was able to crawl from her position beside her patrol car to a position of cover at the rear of Mr. Cisneros' car, and fired two more rounds from her 9mm handgun. (She also ejected three live rounds from her gun, but could not remember why she had done so.) Officer Kula was continuously firing his handgun throughout this time – a total of 18 rounds. He fired these all in succession, emptying his gun, because he did not get any indication that his rounds were striking Mr. Cisneros, and he saw Cisneros

continuing to move and track Officer Boer pointing and firing with what he still believed was a rifle.[25]

Mr. Cisneros ultimately dropped to the ground, in manner that the officers described as slow rather than sudden. His shotgun fell roughly a foot and a half from where he laid near Officer Boer's patrol car. Neither officer was injured by gunfire. There were shotgun pellet strikes along the perimeter wall of the parking structure, and at the front of Officer Boer's patrol car.

At some point during the confrontation, Officer Boer began a radio transmission in which she did not identify herself but stated that someone was shooting at them, so cover officers and two sergeants had already begun heading in the direction of the parking structure when Officer Kula communicated that shots had been fired and gave their precise location. By the time any other officers arrived, the shooting had ceased and Mr. Cisneros had dropped to the ground. When the sergeants arrived they divided tasks. One took charge of the scene, assigning two officers to escort Officers Boer and Kula away from the scene. The other directed another group of officers to form a custody team to secure Mr. Cisneros, who was still breathing and moving slightly. The custody team assembled a ballistic shield and approached Mr. Cisneros, secured his shotgun, handcuffed him, and cleared a medical team to move in. Approximately 10 minutes passed between the time of the shooting and paramedics' arrival on the scene to treat Mr. Cisneros.

Mr. Cisneros was transported to the hospital, where he was later pronounced dead. He had nine separate gunshot wounds, seven to the lower extremities, one that grazed his torso, and one that perforated his jugular vein. Mr. Cisneros was a U.S. Army veteran who served in Iraq in 2006 and 2007 and was diagnosed with and treated for Post Traumatic Stress Disorder after he returned home. During the course of the investigation, detectives learned that he had been on the phone with his mother as he pulled to the top of the parking structure. His mother declined to speak with investigators but shortly after the shooting a friend of Cisneros' mother called 911 and stated that Cisneros told his mother that he loved her and that the police were taking him to a "high place" just before she heard loud noises that she believed to be gunshots.

[25] Officer Kula described seeing the barrel of a long gun and believing it was a rifle, which heightened his level of fear for his partner because of his awareness that rifle rounds can penetrate their vests.

A Multnomah County Grand Jury met just over two weeks later and determined that the officers acted lawfully in their own defense and had no criminal liability for Mr. Cisneros' death.

Timeline of Investigation and Review

3/4/2013	Date of Incident
3/22/2013	Grand Jury concluded
4/12/2013	Internal Affairs Investigation completed
4/30/2013	Training Division Review completed
7/15/2013	Commander's Findings completed
8/28/2013	Police Review Board convened

Analysis/Issues Presented

Tactical Decision Making

Because of the suddenness of the subject's aggression on the officers, there was no opportunity to create a tactical plan. The involved officers believed they were going to take a break, talk, and catch up on administrative duties. Instead, they were immediately confronted by a subject firing a shotgun at them. Fortunately, even though they were on break, they were strategic in the placement of their patrol cars, so they were quick to alert to the subject's arrival on their level of the parking structure. Once the subject retrieved and pointed his shotgun at them, the officers reacted to the threat, seeking cover and returning fire. When the subject went down, they held their fire and maintained cover while broadcasting their positions and request for backup officers. They were able to direct cover officers into the scene, letting them know which direction their guns were pointing to avoid a potential crossfire situation. Cover officers arrived and quickly secured Mr. Cisneros so that paramedics could safely respond to the scene and get him to the hospital.

The Training Division Review goes point-by-point through the decisions officers made during this encounter in a wholly complimentary way. Nonetheless, Training recognized that it is always possible to learn from an incident such as this, and held a debrief with the involved officers to discuss tactical theories and options. Reviewers also recommended that Training employ more tactical shooting scenarios that require officers to shoot at moving targets, something they identified as an area for improvement.

Holistic Approach to Mental Health Issues

Both the Detective Division and Internal Affairs investigations contain numerous references to Mr. Cisneros' PTSD diagnosis and possible depression. There is some reference to a history of mental health care in Portland as well as other jurisdictions where Mr. Cisneros had resided since his discharge from the Army. While Officers Boer and Kula had no way to know about Mr. Cisneros' mental health history, nor should it have changed their response to the deadly threat he posed, a complete and holistic review of this incident should have included some discussion of the mental health care Mr. Cisneros received.

In future events involving a subject with a history of mental health diagnoses and treatment, this review could be completed by the Behavioral Health Unit and included among the materials considered by the Police Review Board. This can serve two purposes. First, to identify whether there were deficiencies in the provision of mental health services that could be addressed, not necessarily by the Bureau but by other stakeholders. Given the scrutiny the Bureau is under for its responses to individuals in mental health crisis, it should be working to further its alliances with mental health care providers in any way it can. Second, a fuller understanding of a subject's mental health history can help guide the Training Division as it seeks to derive lessons from a particular incident.

Recommendation 24: When the subject of an officer-involved shooting has a history of mental health diagnoses and treatment, the Behavioral Health Unit should holistically review the mental health issues presented in an effort to further the Bureau's alliances with the City's mental health care providers and identify possible ways in which the subject's needs could have been more effectively addressed prior to the officer-involved shooting. This review should be included among the materials considered by the Police Review Board.

SECTION TWO

Common Themes and Issues

Subjects Intent on Provoking Officers to Shoot

In seven of the cases we examined in this report, there is some evidence that the subject made statements or took actions indicating an intent to precipitate a deadly force encounter with police. The subjects in a number of these shootings were in some type of mental health crisis, and the motivating intent for most appeared to be a desire to end their own lives. Although unknown to officers at the time, all but three of the subjects also lacked the capability to significantly harm the officers.[26]

- Mr. Higginbotham ignored commands by Bureau officers and advanced on two armed officers while holding a large knife.
- After talking about his suicidal intent, Mr. Morgan told the 911 call taker that "I'd actually prefer for a police officer to shoot me at this point."
- Mr. Potter left a suicide note for his wife and, in his car, a letter of apology to the officers, saying "I'm very sorry that I had to . . . make you do my dirty work. I tried to purchase a real gun to do it myself, but couldn't."

[26] Morgan, Tate, and Hatch all pretended to have functioning firearms, but did not; Potter had a pellet gun.

- Mr. Tate's cousin reported to police after the shooting that Mr. Tate had told her earlier that if police came looking for him he was going to act like he had a gun so they would shoot him because he wanted to die.
- A reportedly suicidal Mr. Baker told police after the shooting that he had no intention of shooting at them, but had grabbed his rifle hoping that his actions would cause the officers to shoot him.
- Mr. Hatch can be heard on a bystander's video recording shouting to police, "do somethin'" and "come on in," and when officers held their positions, he said "I'm coming to you then," and then ran toward the officers with a piece of plastic that he held up and sighted as though it were a gun.
- Mr. Cisneros was on the phone with his mother, and told her that he loved her and that the police were taking him to a "high place" or "higher place" just before he retrieved a shotgun and fired at two Bureau officers.

Situations like these are often referred to as "suicide by cop" in the popular lexicon. An entry in Wikipedia defines it as "a suicide method in which a suicidal individual deliberately behaves in a threatening manner, with the goal being to provoke a lethal response from a law enforcement officer." The Police Bureau and many other law enforcement agencies use the term in their training, and media accounts following officer-involved shootings frequently use it to describe any situation in which an individual apparently provokes an officer into firing with the intent of having the officer kill him or her.

The problem with the term "suicide by cop" is that it suggests there was nothing the police could do to avoid the use of deadly force or prevent the individual's death but instead were forced to shoot the subject, creating a temptation or tendency to be less rigorous in the analysis of the officers' performance. This suggestion was articulated quite clearly in the Commander's Review and Findings Memorandum in Morgan: "it is my belief Bradley Morgan was committed to his suicidal plan and no amount of negotiation would have prevented him from forcing the officers to take his life." The inevitably of Mr. Morgan's death was accepted by the Bureau and used to explain away the performance deficiencies noted by the Training Division in its review.

The Training Division response, in contrast, was notable for its willingness to acknowledge that officers retained the ability to impact the outcome, and could have done better. This acknowledgment was key to Training's ability to use the incident to spur significant changes in the way it trains officers to communicate

with people in crisis. While it ultimately concluded officers were justified in using deadly force given the threat presented when Mr. Morgan produced and pointed his replica firearm, Training nonetheless seemed to understand, as the Commander did not, that Mr. Morgan's death at the hands of police was not inevitable.

The same "inevitability" perspective was unfortunately demonstrated in both the Training Review and Commander's Review and Findings prepared in Higginbotham, where both concluded that the incident was "driven" by the aggressive actions of Mr. Higginbotham but neither recognized how a wiser and more informed decision about whether and how to approach the likely armed, violent man in a confined space might have allowed the officers to avoid being in the position where they were "forced" to use deadly force. Simply because a suspect in crisis desires a certain outcome in his confrontation with law enforcement does not mean that skillfully trained and well equipped officers should necessarily accommodate him.

Unlike Morgan, where officers knew from the outset they were dealing with a suicidal individual, situations in which the subject has an intent to precipitate a deadly police response but does not express that to authorities, as in the remaining six cases listed above, present somewhat different challenges to officers. In three of those cases (Potter, Hatch, and Baker) officers had information that they were dealing with a subject in some type of mental health crisis, though Mr. Potter was also the suspect in an armed robbery, Mr. Hatch had reportedly pointed a gun at a security officer, and Mr. Baker was a suspect believed to have just shot another person. In the others, officers were simply confronting subjects accused of a crime (Tate and Higginbotham) or were responding to a deadly assault (Cisneros). As in any scenario, officers in these situations must call on training focused on preserving officer safety and minimizing the likelihood of the need to use deadly force.

In some of these cases, officers commendably observed principles of officer safety and force avoidance, but nonetheless found themselves compelled to use deadly force. In Potter, officers' initial plan to box Mr. Potter's car in was quickly aborted by the responding sergeant, who recognized the tactic was too dangerous, given the suspicion that Mr. Potter was armed. And the officers and sergeants who responded to the call involving Mr. Hatch all recognized the appropriate goal was to contain and isolate Mr. Hatch, with the hopes of stabilizing the situation so that SERT could be summoned to communicate with

him. Despite Mr. Hatch's stated desire to have officers come in and get him, officers all remained on the periphery of the parking lot and used deadly force only when Mr. Hatch ran at them. And in Baker, the on-scene officers staged responding officers in safe positions, controlled the pursuit, and only used deadly force when they suddenly came upon Mr. Baker pointing a rifle at them.

In Tate, however, the reviewing Commander was appropriately critical of the detectives' low key approach to their encounter with Mr. Tate, which he concluded allowed Tate to carry out his plan of pretending to have a gun to trigger the detective's use of deadly force. The Bureau, both Training Division and the Command staff, need to remain vigilant in scrutinizing these scenarios as closely as any officer-involved shooting, identifying both appropriate and inappropriate responses by officers.

With that vigilant scrutiny will come a better understanding of how these situations unfold and how officers can avoid being drawn into a position where the subject's actions could put them in jeopardy and make them feel like they have no options other than the use of deadly force.

Following its critique of these incidents, the Bureau now trains based on lessons learned from these types of encounters – to maintain distance and consider deploying in a manner where officers remain out of the subject's sight, with the goal of making it harder for subjects to force a confrontation – are main points in the curriculum for dealing with what it terms "suicide by cop" scenarios. Training is also now teaching officers when it is appropriate to disengage from a call involving a suicidal person. When no one else is in danger and there is a chance the officers may get pulled into a deadly force scenario or the officers' presence may further provoke the person in crisis, officers now may leave a call and refer it for later follow up to the Bureau's Behavioral Health Unit, which pairs a social worker with an officer and is better equipped to deal with people in mental health crisis.

It is noteworthy that individuals involved in these scenarios are not, as sometimes assumed, people who will kill themselves regardless of what the police do, and therefore police are powerless to change the outcome. In fact, the opposite is true. Sometimes, these are people who have tried to kill themselves, but failed at doing it themselves and now are trying to get the police to do their "dirty work," as Mr. Potter wrote in his note. Mr. Monroe climbed into a position to jump to his death, but instead of jumping he called 911. As Mr. Monroe said to the dispatch operator, not only had he not been able to jump, he would "actually prefer for a

police officer to shoot me at this point." Left to their own devices, these are not individuals who are necessarily going to succeed at suicide.

No one wants the police to take the life of a suicidal person, least of all the police officers who fire their weapons. It is a tragic and traumatic outcome for all. The Bureau needs to remain vigilant in its training of officers in how to communicate with people in crisis while observing sound tactics and principles of officer safety. Moreover, when deadly force is used, the Bureau must be rigorous in its evaluation of the officers' performance and in particular in the tactical review of their actions. Finally, the Bureau also should guard against the language, culture, and mentality that suggests the death of a suicidal individual who appears intent on provoking a confrontation with police is always inevitable.

Recommendation 25: The Bureau's training and review processes should continue to diligently train officers for their encounters with people in crisis; should maintain their rigorous standards for evaluating uses of deadly force, even when it is evident that the subject intended to precipitate the encounter with the desire to have officers end his or her life; and should guard against the language, culture, and mentality that suggests the death of a suicidal individual in such an encounter is inevitable.

Sergeants Assuming Tactical Roles

In four of the shootings we review in this report – Morgan, Baker, Hatch, and Higginbotham – on-scene sergeants assigned themselves to tactical roles despite the presence of officers to whom they could have delegated those tasks. This is a theme we have seen and commented on repeatedly in our reviews of Bureau critical incidents.

In Morgan, Sergeant Holbrook assigned himself to the communication team, approached Mr. Morgan, and ultimately used deadly force. The sergeant in command in Baker assumed a lead position in the initial attempt to bring Mr. Baker into custody. Shortly thereafter, perhaps remembering the proper role of a supervisor in such an operation, he allowed officers in marked units to pass him and lead the pursuit as Mr. Baker accelerated away, managing the pursuit from a position at the rear. Two sergeants involved in Hatch took tactical roles – Sergeant Voeller as a "spotter" for the AR-15 operator on scene who himself also used deadly force, and another on-scene sergeant as a member of the custody

team who secured Mr. Hatch following the shooting. In Higginbotham, the same sergeant involved in Baker arrived on scene post-shooting but became personally involved in securing the knife that Mr. Higginbotham was holding at the time of the shooting, dragging Mr. Higginbotham to a more open area of the car wash where he could be more easily treated, and performed another sweep of the car wash with two other sergeants and an officer.

As we have said in the past, a sergeant on the scene of a tactical incident should take command of the incident, direct resources, and delegate 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.

Of the four cases we noted here, however, the Training Division Review identified the sergeant's tactical role as problematic in just one, Morgan. In that case, Training cited Sergeant Holbrook's decision to put himself on the communication team as inconsistent with training, but the Commander's Review minimized the importance of this error. In Baker, Hatch, and Higginbotham, both Training and the reviewing Commander failed to mention the sergeants' tactical roles or recognize them as being contrary to training. The absence of acknowledgment of or accountability for sergeants' failure to delegate non-supervisory tasks minimizes the effectiveness of the training provided regarding management of critical incidents.

Therefore, we reiterate a two-part recommendation we made in our Second Report, with emphasis on the second part of that recommendation (Second Report, Recommendation 30, p. 106) and advance another recommendation for emphasis of this important doctrine that has largely escaped critique during the Bureau's review:

Recommendation 26: 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.**

Recommendation 27: 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.

Medical Care for Injured Subjects

In each of our reports, we have commented – mostly unfavorably – on the length of time it has taken Bureau officers to secure injured subjects so that paramedics can approach and provide medical care. In the cases we reviewed for this report, we saw some progress toward the goal of rendering aid to injured subjects as quickly as safely possible. The shooting of Mr. Campbell in 2010 was at the time described by the Bureau as a "catalyst for change" on this issue. It appears that change may be beginning to take hold. For example:

- After officers shot Mr. Potter, his gun fell several feet away. After careful review of the situation, Officer Wingfield was confident that with cover from on-scene officers he could retrieve Mr. Potter's gun safely. Officer Wingfield moved quickly to secure the gun so that officers could take Mr. Potter into custody. While waiting for paramedics, Officer Wingfield examined Mr. Potter's wound to see if it needed immediate attention.
- In the shooting involving Mr. Monroe, officers realized that Mr. Monroe did not present a threat and immediately moved paramedics in to the scene to provide medical attention to the injured subject.
- While we suggested that there should have been a Training analysis and Police Review Board discussion of the use of the K9 to pull Mr. Hatch's body away from the presumed gun, officers in that case also used a ballistic shield and moved quickly to safely approach, secure and tend to Mr. Hatch.
- Officers formed a custody team and approached Mr. Cisneros with a ballistic shield within minutes of the shooting, safely securing the scene for medical personnel to respond, despite the fact that Mr. Cisneros' shotgun was within his reach.

In two cases – Morgan and Simms – there were significant delays in getting to the injured or deceased subjects, but only as a result of difficult logistics or unusual circumstances.

- After officers fired at him, Mr. Morgan fell off the ledge of an elevator structure that demanded a significant amount of maneuvering and required officers to borrow a ladder from a nearby fire station in order to gain access.
- After the officers fired multiple rifle rounds at him, Mr. Simms crashed into an apartment building with his vehicle coming to rest partially inside the building so that officers could not see him or even determine if he was still in the vehicle, causing supervisors to conclude they could not safely approach his vehicle without a SERT team.

Two cases reviewed in this report, however, demonstrate continued room for improvement on this issue.

- In Simms, the decision to activate SERT was impacted at least in part by the on-scene sergeants' admitted lack of training and comfort with the use of the ballistic shield. Though shields were available, they told investigators that they did not feel confident their use would sufficiently protect officers, so they instead waited for a SERT response.
- Similarly, in Baker, the sergeant had a ballistic shield available but declined to use it because Mr. Baker was positioned with a .22 caliber rifle nearby and the sergeant did not know whether the shield would protect officers from a rifle round.

These two episodes are disappointing because following Mr. Campbell's death, the singular change touted by the Bureau to promote a quicker response to downed suspects was the equipping of all sergeants' cars with ballistic shields. In addition, the Bureau reported that every sergeant received two hours of training on their efficacy and how to deploy them. As to these three sergeants there was a potential disconnect between their understanding and Bureau expectations, yet the Bureau did not analyze whether the views of the sergeants signaled a need to retrain these sergeants in particular or a broader failure in training sergeants Bureau-wide. The fact that we have seen ballistic shields deployed appropriately and successfully in a number of other incidents suggests the problem may be limited, but the Bureau nonetheless should evaluate its training on this issue.

Recommendation 28: The Bureau should review its training on the use of ballistic shields to confirm that it accurately informs sergeants of the capabilities and limitations of the shield and to ensure that all sergeants receive this training.

Officers Involved in Multiple Shootings

Two of the officers involved as shooters in cases we review in this report – Sergeant Voeller and Officer Clary – have been involved as shooters in cases we reviewed in prior reports, and one officer – Officer Wingfield – was involved in two shootings covered in this report. We addressed a similar issue in our Third Report, where one officer had been involved in a prior shooting that revealed some patterns about his use of deadly force. There, we stated:

> *Every incident is different in its details and in the precise decisions that an officer makes based on those details. Nevertheless, officer-involved shootings are revealing events that show how the Bureau as a whole and its individual officers operate under high-risk conditions in the field. In this regard, it is appropriate and necessary to consider whether two shootings involving the same shooter officer reveal any patterns or parallels that could help inform corrective action or other reforms or remediation.*

We recommended in our prior report that when reviewing an officer-involved shooting the Training Division Review and the Police Review Board examine any prior shootings by involved officers to consider whether there are significant parallels between the officer's tactical decision making in the incidents.

In a 2006 shooting involving David Hughes, then-Officer Voeller confronted a situation not dissimilar from the shooting involving Mr. Hatch in 2013. There, Mr. Hughes was attempting to escape apprehension on a warrant and essentially got trapped inside a parking lot. He had made prior statements about his intent to provoke officers into killing him, and pretended to have a gun. In that case, we criticized the Bureau's review process for failing to question why officers did not slow down their response, and attempt to contain Mr. Hughes rather than quickly confront him at a very close distance. Ironically, we also criticized the sergeant involved in that case for engaging in a tactical role and ultimately using deadly force rather than maintaining a supervisory position and managing available resources.

In this case, Sergeant Voeller, perhaps learning from the Hughes incident, expressly stated his goal was to contain Mr. Hatch and avoid a direct confrontation until SERT could be activated and assume management of the incident. Officers kept their distance and only engaged Mr. Hatch when he ran towards them. Sergeant Voeller made the same questionable tactical decision as

the sergeant in Hughes when he neglected his supervisory role and assigned himself to be a spotter for the AR-15 operator rather than delegating that task to another officer on scene. There is no record that those reviewing Sergeant Voeller's involvement in Hatch considered or were even aware of his involvement in the Hughes shooting.

The multiple shootings involving Officers Clary and Wingfield do not share such similarities. In Officer Clary's prior shooting, the incident involving Ralph Turner in 2011, he fired one round at Mr. Turner, who had fired at and struck another officer, and then followed a sergeant's direction to lay down cover fire so that other officers could rescue the injured officer. Officer Wingfield was involved in both the Higginbotham and Potter shootings reviewed in this report. Those incidents presented very different circumstances – one (Potter) serves as a model for good tactical planning and execution, while the other (Higginbotham) involved some questionable tactical decisions made based in part on insufficient fact gathering. Despite the lack of similarities between each officer's prior shooting, those earlier incidents should nonetheless be evaluated as part of a holistic review of their subsequent uses of deadly force.

This type of evaluation is necessary as well from a risk management perspective. When an officer has been involved in a prior shooting, that will necessarily be a central fact in any subsequent lawsuit filed against the City. If the Bureau did not consider the earlier use of deadly force in assessing the decision making of the officer in the more recent case, it fuels an argument that the Bureau's review process did not fully evaluate the officer's performance history.

We do not mean to suggest that multiple shootings by an officer necessarily points to a problem or concern, only that it is a fact that should be considered and evaluated as part of a thorough review of any critical incident. Moreover, in the days following an officer-involved shooting, the mere fact that an officer has been involved in multiple uses of deadly force should be considered in determining his or her readiness to return to active patrol duty. In addition, the Bureau should consider conducting a command-level debrief with any officer involved in multiple deadly force incidents as part of its regular review of such incidents.

Recommendation 29: When an officer uses deadly force, the Bureau's review of that incident – by the Training Division, Commander, and Police Review Board – should consider any prior uses of deadly force and evaluate whether there are significant parallels between the officer's tactical decision making in the incidents.

Recommendation 30: When an officer has been involved in more than one use of deadly force the Bureau should engage that officer in a command-level debrief of the incidents to help both the Bureau and the officer identify any patterns or parallels between the multiple events that should be addressed through training or other corrective action.

Timeliness of Investigation and Review Process

Our reviews of Portland Police Bureau critical incidents have often noted delays in the investigation and review process that have limited the Bureau's ability to take prompt corrective action, provide constructive feedback to members, or to hold officers accountable in a timely manner. For all of the incidents we have reviewed, the following tables show the length of time from the date of the incident to the Review Board meeting. The first table includes the cases discussed in this report; alongside is a table for all prior cases we have reviewed.

Subject's Name	Date of Incident	Time to Review Board
Moffett	1/1/2011	22 months
Higginbotham	1/2/2011	12 months
Monroe	6/30/2011	16 months*
Morgan	1/25/2012	14 months
Potter	3/26/2012	11 months
Blackmon	7/17/2012	10 months
Simms	7/28/2012	9 months
Tate	8/21/2012	9 months
Baker	9/29/2012	8 months
Hatch	2/17/2013	6 months
Cisneros	3/4/2013	6 months

* 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.

Subject's Name	Date of Incident	Time to Review Board
Perez	3/28/2004	8 months
Vaida	10/12/2005	13 months
Gwerder	11/4/2005	18 months
Young	1/4/2006	13 months
Grant	3/20/2006	16 months
Goins	7/19/2006	12 months
Suran	8/28/2006	20 months
Hughes	11/12/2006	23 months
Carter	12/28/2006	14 months
Bolen	5/22/2007	16 months
Stewart	8/20/2007	15 months
Turpin	10/5/2007	15 months
Spoor	5/13/2008	17 months
Coady	5/15/2008	13 months
Lovaina-Bermudez	8/24/2008	8 months
Campbell	1/29/2010	7 months
Collins	3/22/2010	14 months
Otis	5/12/2010	16 months
Boehler	11/23/2010	19 months
Ferguson	12/17/2010	13 months
Lagozzino	12/27/2010	15 months
Turner	3/6/2011	21 months
Johnson	7/10/2011	13 months

The cases we reviewed in this report demonstrated a steady decline in length of time to investigate and review, largely as a result of the Bureau's response to the United States Department of Justice September 2012 findings letter about the length of the review and investigation process for the application of deadly force. The 2014 settlement agreement between the City and the Department of Justice (DOJ) sets a six month timeline for the Bureau to complete its review process. Investigation and review into the two 2013 cases we have reviewed were both completed in six months, clear evidence the Bureau can meet the new standard.

Many of the cases we considered here, however, were marked by significant delays. The longest of these, Moffett, was delayed every step of the way for unclear reasons – the Internal Affairs investigation took over a year, it was another four months for the Training analysis to be completed, almost two months for the Commander's findings, and four months before the Police Review Board was convened. The delay would have been even longer had the Bureau agreed with the District Attorney's request to postpone the administrative review until the completion of the criminal case against Mr. Moffett, but at the Independent Police Review Division's urging, the then Chief decided to proceed. This should be the Bureau's policy going forward; the internal review process in an officer-involved shooting should not be held up by criminal charges pending against the person at whom officers shot. In any event, the City's agreement with DOJ does not contemplate an exception to its timelines for such circumstances and calls for parallel criminal and administrative investigations in order to compress resolutions.

The delay in Monroe also suffered from unexplainable slowness; the investigation and review itself took 16 months to complete. Even after the Police Review Board met and recommended termination of Officer Reister, the letter informing him of the Chief's decision took almost a year to prepare. While cases in which the Chief determines that termination is the appropriate outcome will necessarily take longer to complete since a discharge letter informing the officer of the Chief's decision must be carefully crafted, it should not take nearly a year to do so.

The Morgan case also suffered delays at nearly every step of the process – Internal Affairs investigation, Training Division Review, and Commander's Findings. In other cases, the delay stemmed mainly from an inordinate amount of time spent by the Training Division preparing its reviews. Training ordinarily completes its analysis within about a month of the completion of the Internal

Affairs investigation, but in several cases that time period was prolonged – six months in Higginbotham, four months in Blackmon, three months in Simms, and two months in Baker.

We understand that at the time of these incidents, there were transitions of personnel that may have led to the confusion and issues with the assignment and completion of the Training Review. If issues still exist in the assignment and completion of the Training Review, the Bureau should address these.

In addition to requiring a 180-day deadline for investigation and review in administrative investigations, the settlement agreement between the City and DOJ places further obligations on the Bureau, set out in Paragraph 123: "If PPB is unable to meet these timeframe targets, it shall undertake and provide to DOJ a written review of the IA process, to identify the source of the delays and implement an action plan for reducing them."

In the DOJ Settlement Agreement Compliance Status Assessment Report issued September 10, 2015, the Bureau was found to be in "Partial Compliance" with this paragraph. In setting out the progress that had been accomplished to date, the Report referenced a proposed solution to the timeline for officer-involved shooting cases proposed by the Bureau's Professional Standards Lieutenant: "As we have previously discussed, my proposal to fix this issue is to eliminate the RU manager's findings and many of the other redundant review stages. This is in line with OIR recommendations, and it would allow us to drastically reduce the time for this case track." The DOJ Report observed that the Bureau could use these observations and suggestions in ultimately developing a plan as required by Paragraph 123 of the settlement agreement.

As a result of the settlement agreement with DOJ, the Bureau's history of dilatory timelines for officer-involved shooting investigations and reviews that we have commented on frequently has now resulted in a contractual court-supervised obligation to comply with specific timelines. It is heartening that the more recent investigative history and DOJ's first report card shows a move toward acceptable standards in this arena, though we caution the Bureau not to let an emphasis on timeliness cause it to compromise the quality and thoroughness of its investigations.

Interviews of Involved Officers – "48-hour" Rule

In each of the 11 shooting cases reviewed, no involved Bureau member provided an account of his actions and observations until at least 48 hours after the incident, and some even later. The "48-hour rule" dictated by the current Bureau labor contract with the Portland Police Association, the union that represents the line officers continues to impede the Bureau from obtaining from officers involved in a shooting an account of why they used deadly force until at least two days after the incident. The City made small progress toward the goal of doing away with the 48-hour rule last fall, when it entered into a collective bargaining agreement with the Portland Police Commanding Officers' Association that no longer includes the requirement that the Bureau give 48 hours advance notice prior to an administrative interview. However, because the Portland Police Association represents the overwhelming majority of officers who have been involved in shootings, the change to the agreement with the commanding officers' union does little to change the status of the Bureau's ability to obtain contemporaneous officer interviews after a critical incident.

As we have stated repeatedly, beginning with our initial report to the City in May 2012, the inability of the Bureau to obtain a statement from the involved officers the night of an incident is inconsistent with best investigative practices. Bureau investigators are aware of the importance of obtaining contemporaneous statements from witnesses as evidenced by their tireless work in the hours after these incidents interviewing both officer and civilian witnesses. However, the officers who fired their weapons – those most knowledgeable and whose conduct is being reviewed – are not interviewed for at least two days and often longer.

By agreeing to a contract that requires this delay in the Bureau's ability to compel an interview of the officers, the City requires the Bureau to forfeit the opportunity to obtain pure contemporaneous statements from the involved officers about what each did and why they did it. While the Bureau's investigative machinery works hard to obtain contemporaneous and pure statements of observations from civilian witnesses and officer witnesses, the investigative protocols allowed the involved officers' versions to be subject to contamination and recall issues as a result of the passage of time or exposure to other accounts of the incident from media sources, legal representatives or fellow officers. Moreover, any leads or further investigative guidance that might be derived from the involved officers' version of events are hindered and perhaps lost because of the delayed acquisition of officers' statements.

Some police officer advocate groups have pointed to memory studies which suggest memory improves after an individual has had an opportunity to de-stress, sleep, and process the event before being called upon to provide a recollection as a reason to afford officers up to a three day period before being interviewed. Those advocates, however, undervalue the competing factors detailed above, including the potential for conscious or unconscious contamination during the wait period. Moreover, if police agencies were to accept this premise as paramount, they should likewise delay the preparation of written police reports and the collection of witness, victim, or suspect statements after any event. This clearly would not be consistent with accepted police investigative practices, which teach that subjects, victims, and witnesses should generally be interviewed as soon as they are identified.

Some have questioned whether the real reason for a delay in interviewing officers is to afford the officers the opportunity to either consciously or subconsciously choreograph or tailor their responses with the help of external influences or exposure – in other words, "to get their stories straight." The fact that this belief persists among community members is damaging to the credibility of the police agency and its investigative and review processes and should provide additional incentive for the City to eliminate the 48-hour rule.

In reality, the delay may not afford the officers any advantage whatsoever and may call into question the usefulness of their statements because of the likelihood of memory contamination or memory loss. In talking with officers involved in critical incidents, many have expressed their desire to quickly provide their account of what occurred and have reported that any delay may be counterproductive to their interest in giving their report in a timely fashion and their ability to provide an accurate and useful account. In fact, as noted in the discussion of the shooting involving Mr. Moffett, Sergeant Fort appeared willing to talk freely and candidly about his decision to use force but then declined to do so after consulting with his legal representative.

Ideally, officers involved in shootings would provide voluntary statements to Bureau detectives on the night of the shooting, as many officers routinely do across the country. However, if officers decline to provide such a voluntary statement, as they are entitled to do under the Fifth Amendment of the

Constitution, it is vital that the Bureau then has the ability to order them to provide a compelled statement in the hours immediately after the shooting.[27]

In our First Report, in May 2012, we made the following recommendation regarding the 48-hour rule. In our final report pursuant to our current contractual engagement, we renew the recommendation here.

Recommendation 31: The Bureau and the City should begin as soon as possible a dialogue with the Portland Police Association to remove the 48-hour rule restriction on interviewing involved officers in shootings and in-custody deaths.

[27] To be clear, unlike a voluntary statement, a compelled statement cannot be used by the District Attorney or the grand jury to determine potential criminal liability. Indeed, any one with a role to play in any part of a potential criminal proceeding must be completely walled off from a compelled statement and may not be provided any opportunity to learn what the officer said. So while the Bureau can use the compelled statement during its Internal Affairs investigation and administrative review, the contents of that statement cannot be made public unless or until the conclusion of any criminal proceeding.

SECTION THREE Recommendations

1 The Bureau should ensure that command staff recognizes that it should be the overarching objective of every tactical engagement for the Bureau to influence the outcome. (Report, p.19)

2 The Bureau should ensure that its officers have not misinterpreted the principles behind the 21-foot rule and provide more contemporary training designed to ensure that officers recognize the appropriate considerations in determining whether and when to use deadly force against someone wielding an edged weapon. (Report, p.20)

3 When the circumstances surrounding an officer-involved shooting present Constitutional issues regarding the decision making of involved officers, the Bureau's review process should incorporate, discuss, and assess those decisions. (Report, p.23)

4 When the Chief's disciplinary determination is based on a rationale that contradicts conclusions made in either the Training Division Review or the Commander's Review and Findings, the disciplinary letter should explicitly address the contradiction and set out the reasons for the disagreement. (Report, p.27)

5 The Bureau should implement the recommendation made by the Police Review Board and outside experts following the shooting of Mr. Monroe and move to incompatible lethal and non-lethal weapons platforms so that an officer could not mistakenly load lethal rounds into a less lethal weapon. (Report, p.30)

6 In addition to any discipline imposed, the Bureau should include a targeted retraining component whenever it determines that a member has violated its performance policy. (Report, p.31)

7 The City should ensure that Police Bureau crisis communications instructors regularly provide training to dispatchers, either as part of the Police Bureau's Critical Incident Management Training or during the Bureau of Emergency Communications' annual in-service training. (Report, p.42)

8 The City and Bureau should consider ways to formally bring Bureau of Emergency Communications supervisors or decision makers into the Police Bureau's review process in cases where a dispatcher's judgment or performance is potentially at issue. (Report, p.42)

9 Specialized units performing planned operations in a patrol area that could require assistance from patrol personnel (or could be interfered with unwittingly by patrol personnel) should alert the patrol supervisors and personnel unless there is a documented reason why such an alert could jeopardize the operation. (Report, p.55)

10 The Bureau should continue with its rigorous scenario based training, and should ensure that when it decides on a change in tactics or techniques, that change is communicated to all personnel, not just those who attend more recent training. (Report, p.57)

11 When a K9 is used in a shooting incident, evaluation of the K9 deployment should be part of the Training Division Review, Commander's Review and Findings, and Police Review Board discussion. (Report, p.58)

12 When specialized units are involved in an incident along with patrol units, both Commanders should have a role in preparing the review and findings, based on the relative level of involvement of their personnel. (Report, p.59)

13 The Bureau should review critical incidents with neighboring jurisdictions and attempt to develop universal procedures and best practices for assisting units to alert the handling jurisdiction that they have arrived to assist, as well as radio communication protocols to ensure the most timely and complete sharing of information and to advance principles of officer safety. (Report, p.60)

14 The Commander's Review and Findings and Police Review Board should clearly explain the bases for their conclusions, and where a debrief is suggested on tactical concerns, should ensure that all potential areas are covered. (Report, p.66)

15 Whenever an officer makes a choice between weapons to deploy, the Training Review should include analysis of that choice. (Report, p.67)

16 Whenever an investigation into a critical incident reveals that a Bureau member is not fully aware of policy or training doctrine, Training should evaluate whether that officer's misunderstanding signals a broader need for a Bureau-wide briefing or training. (Report, p.67)

17 The Bureau should review training for supervisors periodically, and when they transfer substantive assignments should ensure they have received all relevant training. (Report, p.68)

18 Internal Affairs supervisors, the Police Review Board, and anyone else reviewing the investigation should be vigilant in reviewing interviews not just to ensure coverage of all relevant subjects but also to monitor the form of the questions asked and to remind investigators to avoid compound, closed, and leading questions. (Report, p.69)

19 The Bureau should develop some mechanism to ensure that any systemic concern raised by a participant during the investigation or in after action reports is evaluated to determine whether or how to address it. (Report, p.71)

20 The Bureau should provide a focused briefing to all supervisors reminding them of the Bureau's expectations and training regarding the advisability of assigning involved officers to tactical roles after a shooting incident. (Report, p.85)

21 The Bureau should devise protocols instructing Commanders to defer to their supervisors any post-incident officer-involved shooting assessment in which they were operationally involved. (Report, p.86)

22 The Bureau should evaluate whether it is appropriate to use a K9 to approach and bite an injured subject following an officer-involved shooting. (Report, p.95)

23 Following incidents that involve outside security personnel, the Bureau should consider ways to engage those security forces in the review process and include them in any after-action plans that impact their roles in such incidents. (Report, p.96)

24 When the subject of an officer-involved shooting has a history of mental health diagnoses and treatment, the Behavioral Health Unit should holistically review the mental health issues presented in an effort to further the Bureau's alliances with the City's mental health care providers and identify possible ways in which the subject's needs could have been more effectively addressed prior to the officer-involved shooting. This review should be included among the materials considered by the Police Review Board. (Report, p.100)

25 The Bureau's training and review processes should continue to diligently train officers for their encounters with people in crisis; should maintain their rigorous standards for evaluating uses of deadly force, even when it is evident that the subject intended to precipitate the encounter with the desire to have officers end his or her life; and should guard against the language, culture, and mentality that suggests the death of a suicidal individual in such an encounter is inevitable. (Report, p.105)

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

27 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. (Report, p.107)

28 The Bureau should review its training on the use of ballistic shields to confirm that it accurately informs sergeants of the capabilities and limitations of the shield and to ensure that all sergeants receive this training. (Report, p.108)

29 When an officer uses deadly force, the Bureau's review of that incident – by the Training Division, Commander, and Police Review Board – should consider any prior uses of deadly force and evaluate whether there are significant parallels between the officer's tactical decision making in the incidents. (Report, p.110)

30 When an officer has been involved in more than one use of deadly force the Bureau should engage that officer in a command-level debrief of the incidents to help both the Bureau and the officer identify any patterns or parallels between the multiple events that should be addressed through training or other corrective action. (Report, p.111)

31 The Bureau and the City should begin as soon as possible a dialogue with the Portland Police Association to remove the 48-hour rule restriction on interviewing involved officers in shootings and in-custody deaths. (Report, p.117)

Appendix

Table of Critical Incidents Reviewed by OIR Group
2004 – 2013

Subject's name	Date	# of involved/ shooting officers	# of rounds fired	Officers' weapon(s)	Hit/ non-hit	Fatal/ non-fatal	Subject's weapon or instrument	Subject's Race	Mental health issues	Officer(s) disciplined?
James Jahar Perez	3/28/04	1	3	9mm	Hit	Fatal	Unarmed	African-American	No	No
Marcello Vaida	10/12/05	2	38	9mm	Hit	Non-fatal	Handgun	African-American	No	No
Raymond Gwerder	11/4/05	1	1	AR-15	Hit	Fatal	Handgun	White	Yes	No
Dennis Lamar Young	1/3/06	1	2	9mm	Hit	Fatal	Drove vehicle at shooting officer	White	No	Yes[a]
Timothy Grant	3/20/06	1	N/A	N/A	N/A	In-custody death	N/A	White	No	No
Jerry Goins	7/19/06	1	4	9mm	Hit	Fatal[b]	Handgun	White	Yes	No
Scott Suran	8/28/06	1	2	AR-15	Hit	Non-fatal	Unarmed	White	No	No
James Chasse	9/17/06	3	N/A	N/A	N/A	In-custody death	N/A	White	Yes	Yes[c]
David Hughes	11/12/06	3	15	9mm (2); AR-15 (1)	Hit	Fatal	Unarmed	White	Yes	No
Dupree Carter	12/28/06	1	2	9mm	Non-hit	Non-fatal	Handgun	African-American	No	No
Steven Bolen	5/22/07	2	10	9mm; AR-15	Hit	Fatal	Shotgun	White	No	No
Leslie Stewart	8/20/07	1	1	AR-15	Hit	Non-fatal	Unarmed	African-American	No	No
Jeffrey Turpin	10/5/07	1	4	9mm	Hit	Fatal	Handgun	White	Yes	No
Jason Spoor	5/13/08	2	2	9mm	Hit	Fatal	Handgun	African-American	Yes	No
Derek Coady	5/15/08	1	2	9mm	Non-hit	Fatal[d]	Handgun	White	Yes	No
Osmar Lovaina-Bermudez	8/24/09	1	3	AR-15	Hit	Non-fatal	Handgun	Latino	No	No
Aaron Campbell	1/29/10	1	1	AR-15	Hit	Fatal	Unarmed	African-American	Yes	Yes[e]

Table of Critical Incidents Reviewed by OIR Group
2004 – 2013

Subject's name	Date	# of involved/ shooting officers	# of rounds fired	Officers' weapon(s)	Hit/ non-hit	Fatal/ non-fatal	Subject's weapon or instrument	Subject's Race	Mental health issues	Officer(s) disciplined?
Jack Dale Collins	3/22/10	1	4	9mm	Hit	Fatal	X-acto knife	White	Yes	No
Keaton Otis	5/12/10	4	32	9mm	Hit	Fatal	Handgun	African-American	Yes	No
Craig Boehler	11/23/10	1	3	AR-15	Hit	Fatal[f]	Handgun	White	No	No
Darrryll Ferguson	12/17/10	2	20	9mm	Hit	Fatal	Replica 9mm BB gun	White	No	No
Marcus Lagozzino	12/27/10	1	4	AR-15	Hit	Non-fatal	Machete	White	Yes	No
Kevin Moffett	1/1/11	1	1	9mm	Non-hit	Non-fatal	Handgun	African-American	No	No
Thomas Higginbotham	1/2/11	2	12	9mm	Hit	Fatal	Knife	White	Yes	No
Ralph Turner	3/6/11	2	4-5; then cover fire	9mm; AR-15	Non-hit	Non-fatal	Rifle	White	Yes	No
William Kyle Monroe	6/30/11	1	4	Less-lethal shotgun loaded with lethal rounds	Hit	Non-fatal	Unarmed	White	Yes	Yes
Darris Johnson	7/9/11	3	N/A	N/A	N/A	In-custody death	N/A	African-American	No	No
Brad Lee Morgan	1/25/12	2	5	9mm	Hit	Fatal	Replica handgun	White	Yes	No
Jonah Aaron Potter	3/26/12	4	7	9mm (2); M4 (1); M16 (1)	Hit	Non-fatal	Pellet gun	White	Yes	No
Juwan Blackmon	7/17/12	1	1	9mm	Hit	Non-fatal	Handgun	African-American	No	No
Billy Wayne Simms	7/28/12	1	6	AR-15	Hit	Fatal	Handgun (unloaded)	White	No	Yes[g]

Subject's name	Date	# of involved/ shooting officers	# of rounds fired	Officers' weapon(s)	Hit/ non-hit	Fatal/ non-fatal	Subject's weapon or instrument	Subject's Race	Mental health issues	Officer(s) disciplined?
Michael Tate	8/21/12	1	2	9mm	Non-hit	Non-fatal	Cell phone	Latino	Yes	No
Joshua Baker	9/29/12	2	17	9mm; AR-15	Hit	Non-fatal	Rifle	White	Yes	No
Merle Hatch	2/17/13	3	19	9mm (2) AR-15 (1)	Hit	Fatal	Plastic phone handset	White	Yes	No
Santiago Cisneros	3/4/13	2	22	9mm	Hit	Fatal	Shotgun	Latino	Yes	No

[a]The Bureau made the decision to terminate the shooting officer. The decision was overturned by the Arbitrator, and he was instead suspended for 30 days.
[b]After being struck by the officer's gunfire, Mr. Goins raised his gun to his own head and shot himself. The Medical Examiner ruled the cause of death to be suicide.
[c]The Bureau determined the involved sergeant violated policy on medical care for subjects following the use of the Taser and ordered a debrief.
[d]After both of the officers' shots missed, Mr. Coady shot himself in the head. The Medical Examiner ruled the cause of death to be suicide.
[e]The Bureau made the decision to terminate the shooting officer. The decision was overturned by the Arbitrator, and that decision was recently confirmed on appeal.
[f]None of three rounds fired were deemed fatal, but Mr. Boehler died of smoke inhalation in the ensuing fire in his house.
[g]The Bureau determined an on-scene sergeant violated policy regarding operational planning and supervision and ordered a command counseling.

---------Reviewed in OIR Group's Report Concerning the In-Custody Death of James Chasse, July 2010
---------Reviewed in OIR Group's Report on Portland Police Bureau Officer-Involved Shootings, First Report, May 2012

---------Reviewed in OIR Group's Report on Portland Police Bureau Officer-Involved Shootings, Second Report, July 2013
---------Reviewed in OIR Group's Report on Portland Police Bureau Officer-Involved Shootings, Third Report, November 2014
(no shading) Reviewed in OIR Group's Report on Portland Police Bureau Officer-Involved Shootings, Fourth Report, January 2016