Report to City of Portland

PORTLAND POLICE BUREAU OFFICER-INVOLVED SHOOTINGS

Sixth Report / January 2019

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Foreword

This is OIR Group's Sixth Report on Portland Police Bureau critical incidents. Counting the nine incidents we review in this report, we have examined a total of 50 officer-involved shootings and in-custody deaths during our work with the City over the past eight years, occurring as early as March 2004 and as recently as May 2017. We provide some basic facts about these 50 critical incidents in a table attached as an Appendix to this report.

As laid out in the table, subjects died in 27 of the 47 officer involved shootings. Over half of the 50 subjects at whom officers fired or who died in police custody had a history of mental health issues or were experiencing some type of mental health crisis (29 total). In 22 of the officer-involved shootings, subjects carried operable firearms; in eight they were armed with knives or other edged or potentially deadly weapons (crowbar or machete). Beginning with a shooting incident in December 2010, seven subjects have brandished realistic-looking replica handguns. Thirteen of these 50 critical incidents involved African-American subjects; three involved Latinos; and the remainder (34) involved white subjects. All of the involved subjects were men.

While it is useful to see this information compiled in a table, our reviews focus on the 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. More significantly, we examine the Bureau's internal investigations – for thoroughness, timeliness, and effective identification of officer decision making that falls below the Bureau's expectations and standards. And we evaluate how effectively internal reviewers develop and implement action plans to address individual officer performance as well as broader systemic issues. Our review is focused on

how the Bureau performs these critical internal assessments, as the agency has ultimate responsibility for effectively using investigation, analysis, review, accountability, and remediation to meet the overarching goal of reducing future use of deadly force events.

While there is no one broad unifying theme of this report, the cases we review here share similarities. In three of the nine incidents, subjects advanced on officers with potentially deadly weapons (in two cases a knife and in one, a crowbar) and officers stumbled or fell while trying to back away, placing them at a tactical disadvantage that resulted in officers believing that deadly force was the only option. In two of these incidents, subjects were armed with realistic-looking handguns that turned out to be replica firearms, not capable of doing great damage. And in three incidents, officers were fired upon by subjects prior to returning fire.

In four of these nine officer-involved shootings, there is evidence to suggest the subject intended to engage police with the goal of ending his own life. This was a theme of a past report (Fourth Report, January 2016), where a startling seven of 11 incidents involved suicidal individuals apparently intent on provoking a deadly force encounter with police. We were critical in that report of the use of the term "suicide by cop" to describe this phenomenon suggesting that the shooting was inevitable, and officers powerless to change the outcome. We were pleased to note that the Bureau did not use this language in connection with these more recent cases, and that, in one incident in particular, officers showed patience in dealing with an armed, apparently mentally ill subject, even as he fired his weapon into the ground. (Unfortunately in that case, involving Michael Johnson, officers ultimately shot and killed the subject when he fired his weapon at them.)

Nonetheless, we did see articulated in review documents the persistent notion that there was nothing officers could have done to change the course of events that ultimately led to the officers' use of deadly force. While the reality may be that an officer had a reasonable fear for his life or safety as the result of a subject's actions at the moment the officer fired his weapon, it is rarely true that officers and their supervisors had no alternative courses of action in the time leading up to the shooting that are worth consideration. In its internal review of these incidents, it is critical that the Bureau consider these alternative scenarios. A thorough and constructive review demands that those examining the incident – in the Training Division, Bureau management, and at the Police Review Board – critically assess ways that personnel might have altered their response as a way to promote continuous growth and learning.

The Bureau has a positive record in recent years of conducting criminal and internal affairs investigations that are thorough and fair, although as detailed below, we were concerned in one case about witnesses who were identified during the internal affairs investigation but not interviewed. Its internal review mechanisms – Training Division Reviews and Commander's Memoranda – generally identify and document some significant performance issues, though we identify additional issues in this report that were not raised.

Unfortunately, even when performance issues are identified by Training or management earlier in the review process and recommendations are advanced for improvement, it apparently is the rare case when those internal recommendations are subsequently formally considered, let alone implemented. The Police Review Board is a unique feature of the Bureau's administrative review process, particularly in its inclusion of community members. But its current makeup, orientation, or structure does not appear to be serving as effective an independent check on officer performance or systemic improvement as initially envisioned. In recent years, we have not seen a Review Board finding that recommends formal discipline, and few systemic recommendations made earlier in the review process are formally considered and advanced by the Board for the Chief's consideration. As we did in our last report, we make additional structural and training recommendations designed to make the Review Board process more robust. However, if tangible results are not achieved, a more significant overhaul of the Review Board may be an issue for future discussion.

One of the cases we review here – the officer-involved shooting of Quanice Hayes – engendered protests and strong reactions in segments of the Portland community who responded to the shooting in the context of notorious recent events nationwide involving the deaths of young African-Americans at the hands of the police.

It is undeniable that currently nearly every negative interaction between the police and African-Americans, both in Portland and nationwide, evokes heightened apprehension and concern. As the new Chief expressly recognized in remarks made at the beginning of her tenure, the historical role of police officers as agents of segregationists in the South, and the City's own history of racial inequality and displacement provides an important perspective in explaining the reserve of distrust among some in order to inform the Bureau's current efforts to establish trust with the African-American community.

That long history of injustice understandably frames the public analysis of cases like the Hayes shooting. This deep-seated distrust undermines confidence in

findings that excuse officers while providing neither consolation nor satisfaction to frustrated observers and grieving loved ones. And there is understandable frustration – on both sides – when long-simmering tensions prevent effective communication and constructive engagement.

These dynamics are unlikely to be resolved in the immediate future. The history behind them extends beyond law enforcement matters to economic, educational and structural dynamics that contribute to persistent inequality. None of these factors, of course, are within the control of current Bureau officers and executives.

But to ignore them overlooks a critical element fueling the criticism of the shooting of Mr. Hayes as well as other recent incidents. For their part, perhaps the best response police agencies can provide is to endeavor to build a reservoir of goodwill through honest dialogue, receptivity to feedback, transparency, and a demonstrable willingness to evolve and improve. Of course, such efforts cannot preclude the possibility of future controversial incidents. They can, however, enhance confidence in the legitimacy and appropriateness of the Bureau's responses – both systemically and in terms of individual accountability.

The Bureau's newest Chief has spent time engaging with Portland's communities in atypical law enforcement settings – skipping rope with youngsters or moving to the beat of contemporary music. Some dismiss the outreach as a public relations ploy, casting the efforts in a negative light as if somehow "public relations" was not an important part of the mission of a public service agency. More significantly, the media reports of these events show the impact of such leadership where other command staff members model the Chief's initiative. The Chief's willingness to engage with Portland communities on their terms is an important first step toward strengthening bridges throughout the City.

We make 40 total recommendations in this report. This number should not be seen as a suggestion that the Bureau is in crisis or in need of significant overhaul. Rather, we view our recommendations in the context of an attentive police agency continually striving to improve. The Bureau's systems and processes function at a high level and many of the types of recommendations we make to other agencies we review are remedial by comparison – the types of things that Portland officers, investigators, and executives have been doing for many years. Our

recommendations for the Bureau can be seen as "graduate-level" work, if you will, intended to put the Bureau at the upper echelons of American policing.

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

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

Scope of Review

With this report, we have examined all officer-involved shootings and in-custody deaths for which the investigation and administrative review was complete by the end of 2017. As we have done for each of our prior reports, we reviewed all of the Bureau's investigative materials for each of the nine critical incidents we evaluate here, including the Detectives' and Internal Affairs' investigations, as well as grand jury transcripts where available. We also read and considered the Training Division Review and materials documenting the Bureau's internal review and decision-making process connected with each incident. We requested, received, and reviewed relevant training materials, referred back to training materials we reviewed for our prior reports, and interviewed current Training

Division personnel. We talked with Bureau executives regarding questions that were not answered in the initial materials provided and requested additional documents that were responsive to those questions.

Our analysis centers on the quality and thoroughness of the Bureau's internal investigation and review of each of the incidents presented. We look at relevant training and policy issues, and corrective actions initiated by the Bureau. We do not focus on whether any particular shooting, or related tactic or use of force, is within policy, but do point out where we see officer performance that appears to be inconsistent with Bureau directives and expectations. We also identify issues that were not identified, addressed or thoroughly examined by the investigation and review process that could have impacted the Bureau's findings on the appropriateness of the force or other tactical decision making or resulted in a lost opportunity for remediation or improvement.

SECTION ONE

Officer-Involved Shootings

Summary and Analysis

June 12, 2014 ◦ Nicholas Glendon Davis

On the date of the incident, in the early morning hours, two officers were dispatched to a strong-arm robbery in a wooded area within the city limits of Portland. The complainant told officers that he was traveling in the area on his bicycle, and looking for metal scraps that could be turned in for recycling. The complainant further said he encountered a subject, later identified as Nicholas Glendon Davis, who confronted him and told him to leave because he was trespassing. When the complainant asked if he could retrieve his bicycle that he had laid down while scavenging for metal, Davis told him no. The complainant said Davis started swinging his fists at him and he started to run away. The complainant indicated that he fell which allowed Davis to catch up to him and punch him a couple times in the forearm before he was able to push him away and escape. As the complainant left the area, he said he saw Davis walk with his bicycle off the trail and into the woods.

Officer Robert Brown and another officer arrived at about the same time to the dispatched location. They located Davis walking in a wooded area and Brown called out for him to stop and walk over. Mr. Davis did so and told officers that he was the real victim in that the complainant had attacked him while he was trying to sleep. Officer Brown asked the person for his name, and the subject

identified himself as Nicholas Glendon Davis. Officer Brown ran a computer check and found an outstanding third-degree theft misdemeanor warrant for his arrest. The complainant (who talked with officers later) said he did not want to press charges but just wanted his bicycle back. The officers instructed the complainant to retrieve his bicycle.

While talking with the officers, Davis vacillated from agitated to calm and again agitated. During the conversation, Mr. Davis articulated irrational thoughts. At some point, without warning or provocation, Davis lifted his shirt and pulled out a three-foot long crowbar that he held up over his head as he advanced toward Officer Brown. As Officer Brown backed up, he tripped over a guy-wire causing him to fall. As Davis continued to approach, Officer Brown fired two rounds at Davis who staggered back and fell into the wooded area off the trail. The partner officer had observed Davis procure the crow bar and advance on his partner and said he was about to fire when he heard Officer Brown discharge his weapon.

While Officer Brown initially proceeded to check on Davis, his on-scene partner instructed him to wait for additional officers to arrive. Davis was motionless and not following commands. Eventually, back up officers arrived who handcuffed Davis. Paramedics were allowed on scene and pronounced Davis deceased.

The grand jury determined that the shooting was justified. The Police Review Board convened and recommended that the Chief find the shooting to be within policy.

Timeline of Investigation and Review

6/12/2014	Date of Incident
7/1/2014	Grand Jury concluded
7/22/2014	Internal Affairs Investigation completed
9/9/2014	Training Division Review completed
10/21/2014	Commander's Findings completed
12/3/2014	Police Review Board
12/17/2014	Case Closed

OIR Group Analysis

Tactical Planning and Communication

Failure to Frisk or Search the Subject

The Training Division Review opined that because officers had no information or made no observations that Mr. Davis might have been armed, circumstances did not meet the legal threshold for frisking Mr. Davis. The Training analysis does not consider alternative legal bases for executing a search or frisk, namely, that eventually officers discovered an outstanding warrant for Mr. Davis and the fact that he may have just been involved in a strong-arm robbery. A search incident to arrest or detention would likely have been justified. Alternatively, the analysis suggests that the officers could have requested Mr. Davis' consent to search his person for weapons. The Training analysis concluded that while the officers' actions were consistent with training they were not the most effective method or tactic but failed to consider whether there were other legal bases to support a stop or frisk.

In our Fifth Report (January 2016 – after the date of this incident and subsequent investigation), we recommended that when a Constitutional legal issue arises, The Bureau should consult with an attorney who has a legal background in Fourth Amendment jurisprudence. We renew that Recommendation here.

> RECOMMENDATION 1: When a legal issue arises regarding the Fourth Amendment, the Training Division should consult with an attorney with a legal background in Constitutional jurisprudence.

Failure to Communicate a Plan

The Training Division Review noted that after Officer Brown notified Mr. Davis that he had an active misdemeanor warrant for theft, Davis started to become anxious. Officer Brown stated that he tried to de-escalate the situation by explaining to Mr. Davis that the warrant was not a big deal and the complainant only wanted his bicycle back.

Officer Brown stated that he had not yet decided if he was going to take Mr. Davis into custody or whether he was going to let him go. Officer Brown said that he was planning on calling for backup assistance if he decided to effectuate

an arrest but wanted to deal with the recovery of the bicycle first. Officer Brown said he believed that it was going to require a fight to take Mr. Davis into custody but had not discussed a plan with the other on-scene officer. The Training Division Review opined that Officer Brown should have communicated his plan to the other on-scene officer on whether to take Mr. Davis into custody and found that while the officer's actions were consistent with training they were not the most effective method or tactic.

Implementing Training Division Recommendations

The Training Division Review made the following systemic recommendations about officer training based on its review of the Davis officer-involved shootings:

- Emphasis in scenario-based training that a relatively routine encounter can quickly lead to a high-risk situation
- Emphasis on good communication during tactical events
- Firearms program should instruct on shooting from positions other than standing such as from a kneeling or prone position
- Defensive tactics program should continue to instruct officers on ground fighting and recovering to a stable platform

However, there is no indication that these recommendations advanced by Training were implemented or even further considered. There is no documentation suggesting that the Police Review Board discussed these recommendations. As we note in Section Two, below, any systemic recommendations from Training should be a routine part of all Police Review Board discussions and should be advanced to the Chief for consideration and a Review Board recommendation regarding implementation. The Chief should note in her closing memorandum whether she accepts any of the systemic recommendations and direct a plan for implementation of those she accepts.

In addition, the Training Division Review identified two tactics or methods that were not effective: the officers' failure to frisk or search Mr. Davis and Officer Brown's failure to communicate a plan regarding whether Davis was going to be arrested. However, there is no documentation from the Police Review Board that these issues were considered, discussed, or addressed. Certainly, no action item was derived by the Board to address these identified issues; there is no documentation that they were even used to debrief the involved officers. As we discuss later in this report, the Police Review Board should consider each of the

tactical performance issues identified in the Training Division Review and formulate action plans designed to address them.

Delay in Providing Medical Attention

As noted below, after deadly force was used, Officer Brown moved toward the embankment down which Mr. Davis had fallen to examine him and provide medical attention. However, the witness officer instructed him to wait until additional personnel arrived. Once backup officers did arrive, an arrest team was formed, Mr. Davis was handcuffed, and paramedics were allowed on-scene. It took over five minutes from the time of the shooting before paramedics were able to tend to Mr. Davis, and by that time he had expired.

The Training Division Review noted that after the shooting, both officers holstered their weapons and maintained a position of advantage above Davis. He noted that a sergeant arrived and formed a custody team that gave numerous commands to Mr. Davis prior to its approach. During the approach, the team had lethal cover, handcuffed him, and medical professionals were permitted on scene to treat Mr. Davis.

What the Training analysis did not discuss is whether it would have been appropriate and consistent with training for the on-scene officers to approach Mr. Davis immediately and render medical aid. Factors cautioning against such a move were:

- Officer Brown was not sure whether he had struck Davis with his rounds;
- The location where Davis fell was down an embankment; and
- Officers had not yet located the crow bar.

However, factors suggesting such a decision would have been appropriate were:

- There was no evidence that Davis was armed with a firearm;
- Davis was exhibiting no signs of movement or aggression; and
- Davis was non-responsive to commands.

Perhaps the best evidence of risk assessment that the officers perceived was that they felt safe enough to no longer cover Mr. Davis and holstered their weapons while they waited for backup to arrive. The Training analysis does not discuss whether the two officers could have cautiously approached Mr. Davis with one officer providing lethal cover to make an earlier assessment of his condition and render first aid more quickly.

In evaluating whether the Bureau optimally provided medical attention to an injured individual, the Training Division Review should evaluate whether it would have been consistent with training for initial on-scene officers to approach and render medical aid prior to the arrival of paramedics.

> RECOMMENDATION 2: In evaluating post-shooting performance, the Training Division Review should evaluate whether there were alternative strategies that on-scene officers could have used to render medical aid more quickly.

Investigative Issues

Decedent Information in Detective File

For officer-involved shootings, the Bureau's detective investigations prominently feature at the beginning of the file multiple pages of information about the person who was shot. That information primarily sets out in detail the individual's criminal history and mug shots. Placing that information at the front of the file – before the facts of the incident are even discussed – unnecessarily emphasizes this minimally relevant information.

In an officer-involved shooting, the criminal history of a person shot is usually of little or no relevance to an analysis of its justification, particularly if the shooting officer(s) had no knowledge of it. Rather, as we have stated in earlier reports, focusing on the decedents' "rap sheets" gives this information outsized importance. For these reasons, the Bureau should consider rearranging its detective file organization in officer-involved shootings to place appropriate emphasis on what happened on the date of the shooting as opposed to prior crimes and misdeeds of the decedent.

> RECOMMENDATION 3: The Bureau should not place detailed criminal histories at the beginning of its detective file, to emphasize that the facts of the incident are the appropriate and primary focus of the investigation.

Time Line of Incident

In this case and to their credit, Bureau detectives prepared a detailed time line of events beginning from the 911 call to the paramedics' evaluation of Mr. Davis. The availability of such a time line is extremely helpful in understanding the

length of any interaction between the involved officers and the subject and post-incident decision-making. Many of the Detectives' files we reviewed for this report contained these timelines, but some did not. This investigative analysis should be routinized and prepared for every officer-involved shooting.

> RECOMMENDATION 4: The Bureau should prepare and include in the investigative file a time line setting out relevant events from the initiation of the call for service or initial police contact to the time paramedics initiate evaluation of the person shot.

Timeliness of Officer Interview

Detectives did not interview the officer who used deadly force in this case until six days after the incident. Until recently, if an officer involved in a shooting declined to provide a voluntary statement to criminal investigators, the Bureau was prohibited from obtaining any account of the incident for at least 48 hours, pursuant to an agreement with the officers' union. However, as a result of concerns about the implications of this delay voiced in a number of our reports, as well as by the U.S. Department of Justice and community advocates, the City eliminated the so-called "48 hour rule." Current language now instructs internal investigators to obtain a statement from involved officers "as soon as practicable, but no later than within 48 hours of the event, unless the member is physically incapacitated and unable to provide a statement."

The most serious concern about a delay in obtaining a statement is that it compromises the Bureau's ability to obtain a pure statement about the officer's actual observations and state of mind. Officers' recollections degrade over time. More significantly, either consciously or unconsciously, officers' versions will be contaminated as a result of exposure to external information from third parties or media accounts. Bureau protocols chaperone and segregate officers immediately after a shooting so that this potential for contamination is eliminated in the immediate aftermath. However, if an officer is allowed to go off duty before providing a statement, the Bureau has no effective mechanism to prevent outside sources from influencing an officer's statement.

While the new language is a significant improvement over the "48 hour rule," we will be interested to learn how the Bureau implements the "as soon as practicable" language. Generally, following an officer-involved shooting, attorneys for the involved officers respond to the location. Thus, it would seem "practicable" that

a statement could be obtained from the officers prior to them being released from their shift. If, however, the new directive is interpreted to allow that an involved officer is interviewed 47 hours after the incident, the same risk of contamination exists and the process would suffer the same infirmities as the initial rule. Because we have yet to review a shooting in which the new policy language was interpreted and implemented, we will refrain from making a formal recommendation at this juncture. However, we are hopeful that the Bureau will interpret "as soon as practicable" to mean prior to the end of an involved officer's duty shift.

March 22, 2015 ◦ Christopher Healy

On the date of the incident, Officer Thomas Clark was dispatched to a radio call indicating that the complainant had caught a subject inside his house. Officer Royce Curtiss was also dispatched and both responded with emergency lights and siren.

When Officer Clark arrived he observed the subject, later identified as Christopher Healy, across the street from the dispatched location. Officer Clark observed a man holding onto Healy, later identified as the 911 caller. Clark waited a matter of seconds for Officer Curtiss to arrive and then started his approach to the two persons.

The officers gave several commands to the two men and they separated from each other. Officer Clark later reported that a black shirt being held by Mr. Healy was now covering up his hands. Officer Clark ordered Healy to show him his hands but he failed to comply. At some point, Mr. Healy dropped the black shirt covering his hands and Officer Clark immediately observed him holding a knife.[1]

According to Officer Clark, Healy then lunged at his throat. Officer Clark moved back away from the knife and used his hand to slap Healy's hand downward. Officer Clark felt an impact on his chest and immediately backed away from Healy to create distance. Officer Clark drew his firearm as he was backing away while Mr. Healy began to wave the knife[2] in a figure eight motion. Officer Clark repeatedly ordered Healy to drop the knife.

Officer Clark reported that Healy then lunged at him a second time. Officer Clark fired two rounds at Healy. Officer Clark reported that Healy stopped his advance but was still standing. Officer Clark gave Mr. Healy repeated commands to get on the ground but he did not comply. Officer Curtiss, who was positioned nearby, then used his Taser on Healy, which caused him to go to the ground.

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[1] Officer Curtiss did not report that Mr. Healy's hands were concealed by his shirt but did indicate that after the men separated, Healy immediately produced a knife and advanced on the officers.

[2] Officer Clark said he was familiar with the type of knife, which was specially designed for knife fighting.

A third officer arrived as the shooting occurred. The three officers developed a plan to take Healy into custody and he was handcuffed. Medical aid was summoned and the third officer monitored Mr. Healy's breathing. Another responding officer applied a trauma dressing to Mr. Healy moments before medical arrived. Mr. Healy was transported to a local hospital but succumbed to the two gunshot wounds, one to his arm and another to his chest and abdomen. While Officer Clark was not injured in the chest area, his vest showed defects that may have been caused by the knife.

The matter was presented to a grand jury, which found that the use of deadly force was justified.

Timeline of Investigation and Review

3/22/2015	Date of Incident
4/22/2015	Grand Jury concluded
5/13/2015	Internal Affairs Investigation completed
5/14/2015	Training Division Review completed
6/23/2015	Commander's Findings completed
7/29/2015	Police Review Board
8/9/2015	Case Closed

OIR Group Analysis

Tactics and Communication

Failure to Accurately Communicate Arrival On-Scene

As noted above, a third officer arrived at about the time of the shooting and after the two initial officers had been on scene for at least several minutes. However, PPB's computer records show him arriving first at the location. This is because the third officer was several blocks away from the call when he placed himself "on scene" via his in-car computer. More significantly, the incident timeline

prepared by the Bureau does not indicate that Officer Clark, who arrived first on scene, ever communicated via either radio or computer that he was on scene.

In modern day policing, it is essential that officers communicate through their radio or in-car computers when they arrive at a call. It is equally important that they communicate accurate information. In this case, Officer Clark failed to alert communications that he ever arrived on scene, and the third officer inaccurately placed himself at the location minutes prior to actual arrival. Although identified in the investigative file, these issues were neither addressed nor remediated during any aspect of the Bureau's review process. The Bureau directives on radio or in-car computer use do not include any apparent expectations that an officer will accurately communicate when she or he is on scene to a dispatched call. Consistent with other similarly situated police agencies, such directives should exist.

> RECOMMENDATION 5: The Bureau should devise directives requiring officers to accurately communicate when they are on-scene at a dispatched call.

Disavowal of the 21-Foot Rule

In our Fourth Report (January 2016), we discussed the origins of the so-called "21-foot rule." Based on one trainer's unscientific "experiments" that concluded an armed attacker could clear 21 feet in the time it took most officers to draw, aim, and fire their weapon, officers came to see the "rule" as legal justification for shooting a person with a knife that is less than 21 feet away. A preferred way of addressing this concept, though, is as a warning to officers to think defensively when confronting a subject with an edged weapon – to seek distance and cover to buy time and create additional options for dealing with the threat. When interviewed as part of this investigation, Officer Clark referred to the 21-foot rule when describing his perceived threat: "…with that 21-foot rule he can literally come to me and kill me before I can even draw my weapon."

We understand that the Bureau does not train its officers on the "21-foot rule" but the statement of Officer Clark is evidence that its impact still existed within the Bureau, at least as late as 2015.[3] When an officer-involved shooting demonstrates that an officer has some lingering attachment to the 21-foot rule, it is incumbent

[3] We note that in other, more recent incidents involving edged weapons we reviewed for this report officers made no mention of the 21-foot rule.

upon the Bureau to debrief the issue with the specific officer so that they have a clearer understanding of principles of distance, cover, and other officer safety tactics consistent with actual Bureau training doctrine.

> RECOMMENDATION 6: When an officer-involved shooting reveals statements by officers referencing a disregarded tactical principle such as the 21-foot rule, the Bureau should debrief the officer regarding its preferable tactical philosophy.

Post-Incident Decision-Making

The Training Division Review found the on-scene officers' tactics, decision-making, and uses of force consistent with training. It also found post-scene decisions consistent with training. The analysis noted that inconsistent with Critical Incident Management protocols, no officer was assigned to ride in the ambulance with Mr. Healy when he was transported away from the scene. While opining that best practice would have been for an officer to accompany Mr. Healy, the analysis noted that supervisors were concerned with security at the scene due to several hostile witnesses and did not feel they had sufficient resources available at the time in order to accomplish this mission. Instead, supervisors instructed an officer to meet the ambulance at the hospital as a reasonable and next best available option.

Certainly, the transport of Mr. Healy should not have been delayed due to a lack of Bureau personnel to ride with him in the ambulance. And while the decision not to follow Critical Incident Management protocol may have been appropriate in this incident, the investigation revealed a concern regarding supervisor awareness of the directive.

When the on-scene officer in charge was interviewed and asked about whether there was a directive that an officer travel with the subject in the ambulance, he indicated he was not sure if there was and thought it was an advisement as opposed to a directive.

The Training analysis recommended that the Training Division needed to continue to instruct supervisors on the concepts delivered in the Critical Incident Management Response Class. Based on the on-scene supervisor's lack of certainty about the directives, this recommendation should have been accepted and implemented. There is no documented evidence that it was.

RECOMMENDATION 7: The Training Division should continue to instruct Bureau supervisors on the directives required during the management of a critical incident.

Investigative Issues

Identified Witnesses Not Interviewed

The Portland Police Bureau, per agreement with the United States Department of Justice has agreed to complete the investigative and review process within 180 days. In this case, the investigation was "completed" in 149 days but the following identified witnesses were not interviewed:

- Investigators traveled to an alleged eyewitness' home to attempt to interview her. The witness' mother indicated that the witness was home but she declined to be interviewed. Investigators left business cards but the witness did not contact investigators.

- Investigators also attempted contact with four identified juvenile eyewitnesses by leaving voice mail messages on cell phones. None of the juvenile witnesses replied to the messages.

- Investigators traveled to a residence to re-interview the individual who had called 911 and was holding onto Mr. Healy when officers arrived.[4] They knocked on the door but received no response, left a business card, but received no reply.

- Investigators called the private ambulance service to attempt to interview a paramedic who responded to the location. A representative for the company indicated that a subpoena would be required before the paramedic could be interviewed.

- Investigators attempted to interview a Portland Fire Bureau firefighter who responded to the scene but was informed that the firefighter was not available until the subsequent week.

After the investigation was completed and during the review process, the Independent Police Review division of the City Auditor's Office reminded

[4] Fortunately, PPB detectives had initially interviewed the witness on the date of the incident.

Internal Affairs that it had subpoena authority that could assist in having witnesses cooperate.

The litany of witnesses who were identified but not interviewed raises concerns about the completeness of the investigation. While reluctant witnesses sometimes make it difficult for investigators to obtain a full account of an incident, in Portland investigators can use IPR's subpoena authority to gain cooperation. Certainly, the rescue witness could have been interviewed by the simple issuance of a subpoena and the civilian witnesses may have agreed to cooperate if subpoenas had been issued. And most concerning, the unavailability of the fire fighter for less than a week should not have resulted in a determination to close the investigation without interviewing him.

One question raised by this is the degree to which the internal deadlines imposed for completion of the investigation due to the PPB and Department of Justice agreement may be causing investigators to forego interviews for the sake of meeting the artificial time line. Clearly, the thoroughness of an officer-involved shooting investigation cannot be sacrificed so that an internal deadline can be met. Internal Affairs managers must ensure that the pressures of completing an investigation "on time" do not impede the more compelling interests in thoroughness and completeness.

> RECOMMENDATION 8: The Bureau should use IPR's subpoena authority when necessary to achieve cooperation from witnesses.
>
> RECOMMENDATION 9: Internal Affairs should ensure that all reasonable efforts are made to interview identified witnesses even if doing so might impact the deadline for completion of the investigation.

Recording Interviews of Involved and Witness Officers

As a matter of protocol, PPB investigators audio record and transcribe all interviews of involved and witness officers. In many instances, an interview of an officer will result in the officer making movements or gestures to explain his shooting motion or other tactical movements leading up to the shooting. In cases like Ellis, Davis, and Healy – reviewed in this report – where movement of the various actors proves critical, a video recording of the interview would provide the officer a better medium to demonstrate the movements that he/she made and

observed. Video recording would also relieve the interviewer of the often-neglected task of describing gestures made by the officers during their interviews. The Bureau should consider instituting the routine video recording of the interviews of involved and witness officers.

> RECOMMENDATION 10: In officer-involved shooting investigations, the Bureau should video record interviews of involved and witness officers.

Witness Interviews Not Recorded

Detectives reported interviewing several witnesses but did not make audio recordings of the interviews. The Bureau's general practice is to record interviews in officer-involved shooting investigations. Sometimes witnesses will agree to be interviewed but object to the interview being recorded. There may be other impediments to recording, especially in the field when batteries may die or recording devices malfunction.

While we recognize that there may be a reasonable explanation for not recording all witness interviews, the investigative reports should include that explanation for why there was a deviation from PPB practice.

> RECOMMENDATION 11: When a witness objects to the recording of an interview or recording the interview proves impracticable, the investigative reports should provide an explanation.

Police Review Board Findings

The Police Review Board found that the use of deadly force and the subsequent use of the Taser were within policy. It also found that all post-incident decisions were consistent with training and policy.

The Police Review Board recommended that a crime scene diagram or map be included in the case file for review by members in advance of a Review Board meeting. The Review Board found that use of a map or diagram of the incident scene to show relative distances would help Board members better understand the context of the actions taken by Bureau members, subjects, and witnesses.

The Chief accepted the recommendation and assigned implementation to the Detectives Division.

Timeliness of Officer Interview

In this case, Officer Clark was not interviewed until four days after the incident. As discussed above, we look forward to the time when we will be able to review a case in which the officer was interviewed on the date of the incident pursuant to subsequent improvement in investigation protocols.

July 5, 2015 ◦ David Ellis

While on duty in an unmarked car, Officer Scott Konczal and his partner officer observed a man, later identified as David Ellis, near a Portland Police Bureau contact office. The officers later reported that they suspected Mr. Ellis was either considering burglarizing the office or publicly urinating on the building when they first observed him. When the officers drove up to him and attempted to speak with him, he walked away. The partner officer then stepped out of the passenger side of the police car to further engage with Mr. Ellis while Officer Konczal drove parallel to them. Officer Konczal then drove ahead of the two to position his vehicle to block Mr. Ellis.

When the partner officer ordered Mr. Ellis to stop, Ellis reached into his pants pocket, retrieved a folding knife with an approximately four inch blade that was now open and then turned and stepped toward the partner officer. The partner officer quickly backpedaled and fell backwards, breaking his right wrist. Mr. Ellis continued to advance until he stood over the top of the partner officer and began stabbing him, puncturing the officer's left palm with one of the knife thrusts. Officer Konczal observed Ellis advancing on his partner and alighted from the vehicle. By then Ellis was on top of his partner and Officer Konczal was concerned that shooting at the subject could result in his partner being accidentally struck. As a result, Officer Konczal holstered his weapon and withdrew his collapsible steel baton intending to use it on Ellis.

At that point, Mr. Ellis suddenly stood up, turned the knife towards Officer Konczal and appeared as if he was going to advance on him. Officer Konczal started to back up. Mr. Ellis moved as if he was going to stab his partner again. Officer Konczal then put away his baton and fired his handgun once, striking Mr. Ellis in the arm, and causing him to drop his knife.

When uninvolved officers arrived on scene, Officer Konczal and his partner were appropriately removed from their immediate duties. The partner was transported to the hospital for medical attention. Officers formed a custody team, which gave commands to Mr. Ellis to move away from the knife. Ellis somewhat complied but was having difficulty moving. Eventually, Mr. Ellis moved far enough away from the knife so that the custody team believed they could safely approach. The custody team took Mr. Ellis into custody without the use of additional force.

Besides the broken wrist, the partner officer did not suffer additional significant injury. Mr. Ellis survived the gunshot wound to his arm.

The District Attorney found that the use of deadly force was justified. The grand jury indicted Mr. Ellis for attempted murder. The Police Review Board found that the shooting was within policy and that all post-incident procedures were appropriate.

Timeline of Investigation and Review

7/5/2015	Date of Incident
8/25/2015	Internal Affairs Investigation completed
9/13/2015	Training Division Review completed
9/21/2015	Commander's Findings completed
11/4/2015	Police Review Board
11/23/2015	Case Closed

OIR Group Analysis

Officers' Decision to Split from Partner

Initially the two officers remained in their unmarked car while talking with Mr. Ellis. Officer Konczal said he did so because he wanted to approach Mr. Ellis in a "low key" manner. Officer Konczal pulled up alongside Mr. Ellis as he continued to walk away on the sidewalk. Mr. Ellis did not acknowledge Officer Konczal and proceeded to cut through a parking lot, which Officer Konczal interpreted as evasive.[5]

[5] One fact not discussed in the Training analysis is that on the date of the incident the officers, while in uniform, were in an unmarked car. That fact, coupled with the decision to remain in their car, may have provided less clarity to Mr. Ellis initially about whether they were, in fact, police officers. While Mr. Ellis made spontaneous statements about

The Training Division Review noted that officers are trained on the advantages and disadvantages of making contacts from the patrol vehicle. Some of the advantages stated by Training were the ability to initiate and maintain a conversation and the ease with which officers can chase or contain a person if they flee. The disadvantages include the inability to readily go "hands on" and the fact that it places officers in an inferior tactical position.

As noted above, once Ellis declined to engage with the officers and continued to walk away, the partner officer alighted from the patrol car while Officer Konczal drove past the two to try to cut Mr. Ellis off. As a result, the partner officer was forced to engage with Mr. Ellis alone. It was during this engagement that Ellis eventually reached into his pocket, pulled out a knife and moved toward and stabbed the partner officer. At this time, Officer Konczal was apparently still in the car and had to get out to assist his partner. By the time he was able to do so, Ellis had stabbed his partner and was on top of him.

The facts suggest that Officer Konczal's decision to split from his partner, however briefly, left his partner at a tactical disadvantage once Ellis attacked him. The partner officer was forced to defend against a now violent subject while Officer Konczal was in the patrol car. The Training Division Review did not discuss this questionable tactical decision-making, but instead found that all on-scene officer decisions demonstrated sound and effective tactics. The Commander's Memorandum likewise did not discuss the officers' decision to separate, nor did the Police Review Board address it.

> RECOMMENDCATION 12: The Training Division Review, Commander's Memorandum, and internal review process should identify any tactical decision making that results in partners being separated and required to detain subjects alone.

Implementing Recommendations

As we discuss in more detail in the "Common Issues" section, the Training Division Review recommended reinforcement through training of tactics intended to be safer than backpedaling away from an advancing, armed subject, and the reviewing Commander concurred with this recommendation. Unfortunately, there is no indication that this recommendation was embraced or implemented.

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the shooting after he was detained, he was largely uncooperative in providing a detailed account of the incident.

The Commander's Memorandum here further recommended that the Training Division create a video reenactment[6] of the incident along with development of a lesson plan by defensive tactics instructors. The Commander stressed that the incident could be used as a platform to discuss two-on-one officer control tactics[7] along with contact and cover techniques and strategies for patrol officers to think about and apply when in the field.

The Commander also recommended that the Training Division reinstitute defensive tactics and ground fighting skills during annual in-service training and continue to train on such skills at least annually.

As with the Training Division Review recommendations, there is no evidence that the recommendations made by the Commander were ever considered by either the Police Review Board or the Chief's Office. As we recommend more broadly below, the Bureau should create protocols to ensure that all recommendations coming out of the internal investigation and review process are considered by both bodies.

Providing Medical Treatment

When uninvolved officers arrived on scene, Officer Konczal and his partner were appropriately removed from their immediate duties. The partner was transported to the hospital for medical attention.

A custody team was formed and commands were given to Mr. Ellis to move away from the knife. Ellis somewhat complied but was having difficulty moving. Eventually, Mr. Ellis moved far enough away from the knife so that the custody team believed they could safely approach. The custody team took Mr. Ellis into custody without the use of additional force.

In this case, unlike others we have reviewed in prior reports, the custody team was formed and responded quickly to provide medical attention to the downed individual. While all risk had not been eliminated, the custody team found that they had appropriate resources to move toward Mr. Ellis to bring him into custody and provide him timely medical aid.

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[6] We are aware that other officer-involved shootings in Portland have resulted in the production of training videos. The use of real-life scenarios for training purposes is consistent with best training practices.

[7] As discussed above, because the officers decided to split, the situation with Mr. Ellis became a one-on-one encounter when he decided to aggress the officer.

Timeliness of Officer Interviews

Office Konczal was not interviewed until two days after the incident. Subsequent protocols now require officers involved in deadly force incidents to be interviewed as soon as practicable but no later than 48 hours after the incident. We look forward to reporting on the Bureau's compliance with that new standard with the hope that officers will routinely be interviewed before they go off shift.

November 6, 2015 ◦ Michael Johnson

Just after 5:30 in the morning, a man later identified as Michael Johnson walked into the emergency room at Good Samaritan Hospital in Northwest Portland and told the woman working the registration desk that there was a man with a gun outside and that they should call the police. She called hospital security, and the on-duty unarmed guard responded and walked outside with the employees who had seen Mr. Johnson come into the hospital. They identified the man they had seen earlier, standing in an employee parking lot, and did not see anyone else other than some physicians heading into work.

The security guard called the Bureau of Emergency Communications non-emergency dispatch and officers quickly responded as security moved to lock down the hospital. The first responding officers established a staging area from which they could coordinate their efforts to locate and monitor the subject as well as coordinate a perimeter and make efforts to block access to the area. These tasks were complicated by the fact that, even in the pre-dawn darkness, people were arriving at the hospital for work or early morning appointments from various directions by car, bicycle, and on foot. Officers focused on "getting eyes on" the subject and confirmed that he did, in fact, have a gun (a .38 caliber revolver). The handling officer requested an Enhanced Crisis Intervention Team[8] member to respond.

Acting Sgt. Robin Dunbar and Sgt. Robert Quick arrived shortly after the original call and initially shared supervisory responsibility. Officers made a plan to get closer to the subject, utilizing a ballistic shield and moving a police SUV into place ahead of them for cover. This group included the Enhanced Crisis Intervention Team member, who took the lead in attempting to communicate with Mr. Johnson. She called out to him to put down the gun, telling him they wanted to help him. He refused, telling them he was not going to put it down. Throughout this time, he was pacing back and forth, sitting down then standing up, pointing the gun at his head, into the air, or down at the ground. Officers continually reevaluated their positioning as additional resources arrived, attempting to maintain verbal and visual contact with Mr. Johnson while

[8] All Bureau officers receive basic Crisis Intervention training, but some officers elect to go through additional, specialized training in handling mental health crisis calls. These "Enhanced Crisis Intervention Team" officers work regular patrol assignments and are dispatched to crisis calls as needed.

maximizing officer safety. Because Mr. Johnson appeared to be fixated on the police vehicle, officers at some point changed their positions, using a different vehicle for cover.

Eventually the officers attempting to communicate with Mr. Johnson moved out of the ground level parking lot, and up into a parking structure across the street, where they could maintain a better view of the subject and where they had hard cover in the form of concrete barriers.

For the most part, Mr. Johnson was not engaging with the officers who tried to talk to him. He did provide his name, and a series of numbers that officers thought might be a driver's license number or social security number, and officers attempted to use this information to gather background information on the subject. He also told them he was bi-polar and was "going to end it." They checked with the hospital to see if he had been a patient or associated with a current patient. They attempted to locate an address or names of family members to gain some insight in their efforts to communicate with Mr. Johnson but did not get far with any of these efforts.

Acting Sgt. Dunbar requested a Crisis Negotiation Team[9] to respond, and eight minutes later, the Special Emergency Reaction Team (SERT)[10] was activated. A short time later, then-Captain Mike Marshman arrived and assumed the role of Critical Incident Commander. They made the decision to instruct precincts to respond to only priority calls in other parts of the City and to send all available officers to respond to this scene to bolster containment efforts. Over the next roughly 40 minutes, a Crisis Negotiating Team officer attempted to communicate with Mr. Johnson while regularly providing dispatched updates regarding his status. Mr. Johnson for the most part continued his disengagement – variously walking around, crouching, lying down, plugging his ears, and at times pointing the gun to his head or cheek while at other times pointing it down or sweeping it

[9] The Crisis Negotiation Team is made up of negotiators, technical experts, and mental health professionals who respond to situations involving hostages, armed and barricaded suspects, and mental health crises where the subject is considered armed and dangerous. Their role is to communicate with the subject in these situations as well as gather information that may assist in successful communication and resolution.

[10] SERT is a tactical response team that is activated to handle hostage, active shooter, or barricaded suspect incidents, as well as service of high-risk warrants. SERT officers receive specialized tactical training and have access to weapons and equipment that general patrol officers do not have. SERT is not a full-time assignment, but SERT-trained officers respond from their regular assignments when activated.

around. At one point, officers heard him repeatedly saying, "I love you," but he otherwise was not communicating. Negotiators believed that Mr. Johnson likely was responding to some internal stimuli.

As reflected in their subsequent interviews, officers and supervisors had significant concerns for the bystanders in the area. There were windows into office buildings around the parking lot and, despite efforts to shut down all forms of traffic into the vicinity, people still were walking or bicycling in relatively close proximity to Mr. Johnson. Just past 7:00 a.m., Mr. Johnson fired one round from his handgun into the ground. Officers did not respond, but generally reported how knowing Mr. Johnson was willing and able to fire his weapon heightened their apprehension.

Eight minutes later, as SERT officers and others continued to arrive on scene, Mr. Johnson fired a second round into the ground. SERT officers, including Officers Russell Corno and Chad Daul, re-positioned patrol officers while taking over key positions. Corno and Daul relieved the officers who had been providing lethal cover to the negotiating team.

SERT had deployed its armored vehicle to the scene, but supervisors decided initially to keep it out of Mr. Johnson's view because they were concerned it would agitate him and escalate the situation. After he fired the second shot into the ground, however, they decided to move the vehicle into a position where the crisis negotiator could get closer to Mr. Johnson and communicate with him from inside the protection of the vehicle.[11] The negotiating officer attempted to explain to Mr. Johnson that the vehicle was not coming to hurt him but only to facilitate communication.

Just after he told Mr. Johnson about the armored vehicle, the negotiating officer said Mr. Johnson raised the gun, pointed at the level of the parking structure where he and other officers were positioned, and fired one round.[12] The SERT rifle operators both made the same observation (as did several other officers on scene), and returned fire because they concluded that Johnson's actions threatened

[11] The negotiating team was positioned about 50-60 feet away from Mr. Johnson, behind a 40-inch high concrete wall. In order to sufficiently project his voice to address Mr. Johnson, an officer had to stand up and expose his head.

[12] Investigators found a flattened bullet that could have come from Mr. Johnson's gun in the parking structure where the negotiating team and Officers Corno and Daul were positioned.

the lives of the officers on scene. Officer Daul fired his rifle four times, and Officer Corno fired three rounds. Mr. Johnson went down.

Because Mr. Johnson was still holding a gun in his hand and officers observed some movement from him, they did not immediately approach. The armored vehicle was already moving toward Mr. Johnson, so the SERT team decided to utilize it for cover. SERT Sgt. Tom Forsyth directed an officer to fire a less-lethal sponge round to see if Mr. Johnson would respond. That round struck Mr. Johnson's leg and did not prompt any additional movement, so officers approached along with a SERT medic, within about seven minutes of the shooting by Daul and Corno. They began lifesaving efforts, but paramedics declared Mr. Johnson deceased approximately five minutes later, and about an hour and 40 minutes after the initial call.

Mr. Johnson suffered five gunshot wounds – four in his torso and abdomen, and one in his lower leg. The medical examiner also noted "hesitation marks," or superficial incisions on Mr. Johnson's wrists, indicating tentative suicide efforts. He also found what he described as a suicide note written in blue ink up and down his hands and arm. Investigators also found a number of notes with Mr. Johnson, essentially saying goodbye to specific people. The medical examiner deemed the cause of death to be multiple gunshot wounds, but the manner of death to be suicide.

Despite the suicide finding, the District Attorney presented the incident to a grand jury, which concluded the shooting was legally justified. The Police Review Board convened and determined all aspects of the incident to be within policy, but also recommended a Debriefing/Performance Analysis for two involved sergeants stemming from the delay in activating SERT.

Timeline of Investigation and Review

11/6/2015	Date of Incident
12/3/2015	Grand Jury concluded
12/28/2015	Training Division Review completed
1/6/2016	Internal Affairs Investigation completed
2/22/2016	Commander's Findings completed
4/6/2016	Police Review Board
4/14/2016	Case Closed

OIR Group Analysis

Tactical Issues

This situation presented a number of tactical challenges. Officers understood from the outset that they were likely dealing with a person in some sort of mental health crisis who was possibly suicidal. At the same time, they were in an open setting that was difficult to contain and presented substantial risks to uninvolved individuals in the area. In many ways, the tactical performance here can be viewed as indicative of the ways the Bureau has learned from past incidents, in that officers did not replicate decisions that have been the subject of past criticism.

The initial responding officers took their time, designated a staging area, and made a deliberate, tactical approach. Sergeants arrived on scene quickly and appropriately assumed command. The two sergeants initially on scene agreed that Acting Sgt. Dunbar was officially in charge, but Sgt. Quick stayed with her as a sort of mentor. As the Training Review noted, Acting Sgt. Dunbar did not broadcast that she was the incident commander, but this did not create confusion for officers on scene, who clearly understood she was in charge. Throughout the incident, the sergeants communicated with each other in a productive, cooperative way.

The initial responding officers had requested response from an Enhanced Crisis Intervention Team member, and Acting Sgt. Dunbar requested a Crisis Negotiation Team response. Sgt. Quick did a phone consult with SERT, but the official request for SERT activation came eight minutes after the crisis negotiators were activated. Typically – though not required by policy at the time – SERT is activated whenever the Crisis Negotiation Team is requested, because negotiators often need SERT resources to effectively do their job.[13] While neither Training nor the reviewing Commander found the eight-minute delay to be significant, the failure to activate SERT at the same time as the negotiation team was the subject of a Debriefing with both involved sergeants.

Throughout the incident, officers and supervisors maintained effective overall communication, with the negotiating team providing regular updates about the subject's movements and actions. They made efforts to learn about Mr. Johnson so they might better be able to engage with him. He gave them his name, which unfortunately was too common to provide meaningful leads. He also gave a series of numbers to them, which turned out not to be associated with a driver's license or social security number. They checked with the hospital, to see if he had been a patient or was associated with anyone currently admitted and located records on a car in the parking lot that they thought might have been connected to him. While the Bureau should be credited with these attempts at intelligence gathering, none of these efforts resulted in any helpful information.

Most importantly, officers attempted to find a cell phone number for Mr. Johnson. Communicating with him from a distance that provided safety and cover for the officers was challenging, and officers hoped they might be able to communicate by phone. Officers could not locate a number for Mr. Johnson. While there was some discussion of trying to get a phone to him that they could then use to call him, that was ultimately not a tactic they pursued.

The issue of communication was significant, particularly in light of a fatal officer-involved shooting of a suicidal man that had occurred in 2012, in which officers opted not to communicate with the subject by telephone, and left positions of cover in an attempt to build rapport and talk more freely with the young man to convince him not to jump to his death, but in disregard of reports that he was armed. He ultimately drew and pointed a replica firearm at officers, who felt

[13] A SERT response generally takes much longer, because the negotiators simply have to get themselves to the scene, while SERT operators have to retrieve specialized gear before responding.

compelled to fire – just 20 minutes after arriving on scene – because they had placed themselves in such a vulnerable position.

Here, officers sacrificed the ability to more easily communicate with Mr. Johnson in order to remain behind cover, effectively slowing the incident down and giving officers time to try to find a way by which they could effectively but safely communicate with Mr. Johnson. That distance and cover meant officers could exercise restraint even when Mr. Johnson twice fired his weapon into the ground. Unfortunately, even the available cover and distance was not enough to overcome officers' concerns for their own and others' safety when Mr. Johnson fired at them, and this event came to the same tragic end as the earlier incident.

One tactical option considered by those in command was use of the armored vehicle deployed by SERT. That would allow a negotiating team to get closer to Mr. Johnson and communicate from the safety of that vehicle, which is designed to defend against ballistic weapons more powerful than Mr. Johnson's. It also might have given officers the flexibility to utilize a less-lethal weapon in response to Mr. Johnson's actions, because the armored vehicle could move within the effective range of these weapons systems and would provide protection from the .38 caliber revolver they knew Mr. Johnson possessed.

SERT officers began arriving on scene roughly 20 minutes before the shooting and the Critical Incident Commander was weighing how to use available resources. There was a concern expressed that the armored vehicle might agitate Mr. Johnson, and therefore escalate the situation, so they did not immediately move it to within his sight. After he fired his weapon the first two times, however, the commander decided to utilize the vehicle. The shooting occurred just after the negotiating officer advised Mr. Johnson that officers would be bringing in the armored vehicle.

Investigation Staffing

The detective who served as the primary investigator of this incident had first responded to the scene as a member of the SERT team, prior to the shooting. As soon as the shooting occurred and the incident stabilized, he informed the Critical Incident Commander that he would take over the scene as the handling Detective. His assignment with SERT is in an intelligence position, coordinating resources and relaying information between other SERT members and the incident commander. During this incident, he played a peripheral role and was not a witness to the shooting itself or any of the communication efforts with Mr.

Johnson. Nonetheless, his dual role transitioning from being a SERT responder to handling the crime scene and subsequent investigation raises potential concerns.

When the detective testified before the grand jury, he first testified about events surrounding the shooting of Mr. Johnson that he observed, heard, or experienced first-hand, and also described what he learned as a result of his investigative work. It was not clear from his testimony what he knew because he was present when it happened, and what he later learned from interviewing other witnesses while wearing his investigative hat. While the detective's testimony likely did not impact the grand jury's ultimate decision (particularly in light of the medical examiner's determination about suicide), his dual role in this case created an unnecessary lack of clarity in the testimony.

Also, because the criminal investigation focused on the actions of his fellow SERT responders in an incident during which he was on the scene at the time of the events being reviewed, the detective's role as primary investigator raises concerns about objectivity and potential conflicting roles. While we saw nothing in the investigative materials that causes us to question the investigation's fairness or impartiality, even the possibility of creating this perception is not in the Bureau's best interest.

Most importantly, the concerns created by the detective's dual role were avoidable. The Detective Division makes assignments on a rotation basis. The involved detective knew at the time he responded as part of the SERT team that he was the "next up" for an assignment. He could have notified his supervisor at that point of the possibility of a conflict, should the incident result in an officer-involved shooting, and the supervisor could have notified whoever was next in rotation to be prepared to handle this incident. Indeed, the Detective Division has an informal protocol for handling situations such as this in a way that in most cases avoids overlapping assignments, but the Bureau should create a formal policy to avoid having detectives investigate incidents in which they were involved, however minimally.

> RECOMMENDATION 13: The Bureau should adopt a policy or protocol prohibiting a member who was even minimally involved in a critical incident from being part of the investigative team.

Equipment and Resource Issues

There was some concern through this incident about officers being able to effectively communicate with Mr. Johnson while remaining in a safe position, with distance and cover. The lead officer on scene for the Crisis Negotiation Team believed that Mr. Johnson could hear him but chose not to respond or engage because of the internal dialogue he appeared to be struggling with. He was concerned, though, that other members of the negotiating team could not project their voices sufficiently for Mr. Johnson to hear. One option not discussed in the investigative or review materials was the availability of a megaphone or a patrol car's loudspeaker system to attempt to communicate with Mr. Johnson. We understand there may be reasons to question the utility of that equipment in this scenario, but consideration of its use would have added constructively to this review, particularly given the fact that the shooting officers expressed concern about the vulnerability of the negotiator every time he exposed his head above the concrete barrier that served as cover.

Also, the investigation noted that the supervising sergeants requested a K-9 to respond to this incident, to maximize available resources in the event the subject attempted to flee the area. No K-9 officers were available, but no further information is provided as to why, or how frequently this valuable resource is unavailable to officers[14]. As this incident unfolded, there was no obvious opportunity to use the K-9, but that should not deter scrutiny of the issue.

Similarly, as noted in the Training Division Review, none of the uniform patrol officers on scene wore their ballistic helmets, which is part of the standard gear officers are required to carry in their patrol cars. Given the concerns about the limitations of available cover, and how officers sometimes had to expose their heads in order to communicate with Mr. Johnson, donning helmets would have been wise. Training recommended that operations branch members be reminded that ballistic helmets (generally thought of as crowd control gear) can also be used in tactical incidents like this one. Training should also push these reminders out to supervisors as part of their critical incident training.

[14] Supervisors had inquired about the possibility of getting a K-9 officer from another jurisdiction to respond, but it was unclear how that inquiry was resolved.

RECOMMENDATION 14: The Training Division should prepare briefings and/or a Training Bulletin to remind officers and supervisors about the usefulness of ballistic helmets in tactical incidents and should include this information in the curriculum for its critical incident training.

Training Division Recommendations

The Training Division Review made several important recommendations. First, the review noted that Acting Sgt. Dunbar had been in that "acting" capacity for over a year but had not yet attended the full Sergeants' Academy that those formally promoted to the rank are required to complete. Though Acting Sgt. Dunbar's performance here largely met Department expectations, Training recognized that it is unfair and potentially unwise for the Bureau to put its personnel in command of critical incidents without providing them access to all of the tactical leadership training included in the Sergeants' Academy, and accordingly recommended that the Bureau provide basic supervisory training for all of the officers on each sergeant promotional list.

Training also recommended training updates regarding the use of ballistic helmets, referenced above, and a review of SERT directives to consider mandating SERT activation any time the Crisis Negotiation Team is called out. There is no written documentation that the Police Review Board or the Chief's Office considered or adopted any of these recommendations. As we discuss below, the Review Board should formally address every recommendation from Training during its deliberations of an incident and make documented recommendations to the Chief regarding any the Board supports.

Timing of Interviews

Officers Corno and Daul both provided voluntary interviews to Detectives, but not until four days after the shooting. We expect that recent changes to Department policy will result in more timely interviews of involved officers.

Concerns about "Suicide by Cop"

The coroner ruled the manner of death here to be "suicide." He testified to the grand jury about this decision, stating that most deaths following an officer-

involved shooting would be deemed homicides, which is defined as death at the hands of another. However, he stated that when he sees a clear indication that the person intended to get the police to kill him or her, he considers it a suicide. In this case, he said the suicide notes found in Mr. Johnson's pockets, as well as written on his arms and hands, along with what he learned about Mr. Johnson's history of mental illness and seemingly intentional efforts to precipitate a police response were enough to convince him this was a suicide.

In our Fourth Report (January, 2016), seven of the 11 officer-involved shootings we analyzed involved subjects who made statements or took actions indicating an intent to precipitate the deadly force encounter. We cautioned against referring to those cases as "suicide" because it suggests inevitability of the subject's death and invites a less rigorous analysis of the officers' actions. Here, we did not find that the Bureau shortcut its investigation or review process as a result of Mr. Johnson's evident intent to die (despite the fact that the Commander's Memorandum regarding the use of deadly force begins with the observation: "This use of deadly force . . . was driven by Mr. Johnson's desire to end his life.").[15]

Also, as noted above, we found that officers here seemed to employ much of the training developed and re-emphasized following those incidents we reported on in 2016. That training stresses the importance of maintaining distance, seeking cover, deploying in a manner where officers remain out of the subject's sight, all with the goal of making it more difficult for subjects to force a confrontation, even when that may be their intent.

We question the decision of the Medical Examiner to rule Mr. Johnson's death a suicide. While he may have made his desire to end his life clear through his notes, there is evidence (the hesitation marks on his wrists) to suggest that, left to his own devices, he may not have been able to fulfill his suicidal intent. Through his actions, Mr. Johnson did seem intent on provoking a deadly force encounter with officers, but as with many deaths that are deemed "suicide by cop," Mr. Johnson was not necessarily someone who would have killed himself regardless of the officers' actions. And even if he were intent on provoking the police to shoot and kill him, the dynamic of an officer-involved shooting is not the same as a person actually taking his own life.

[15] We have repeatedly made the point that the Bureau should not consider incidents or outcomes to be "driven" by the will of the subject, but instead should focus on whether officers used all reasonable means to "drive" the outcome.

Moreover, a finding of "suicide" by the Medical Examiner could imply that officers' use of deadly force need not be examined by a grand jury for criminality. If, in fact, there was no "homicide" as a result of the officers' use of deadly force, the homicide statutes in play under Oregon law would arguably not even apply. Even, as in this case, where there is a grand jury proceeding, when a Medical Examiner opines before the grand jurors that an event was a suicide, any question of potential criminal culpability for the officers is effectively obviated.

> RECOMMENDATION 15: The Bureau should initiate a dialogue with the Medical Examiner regarding the potential legal and accountability implications of a finding that a use of deadly force by police officers constitutes a suicide.

May 24, 2016 ◦ Timothy Bucher

The Bureau of Emergency Communications received a 911 call on the evening of the incident. The caller put the phone down but left the line open. The dispatcher could hear arguing between a man and a woman, including verbal ranting, a slap, threats to "kill people who were going to kill him," and mention of a gun. A male voice said he had a gun and is going to kill someone as well as that the police were "his ticket out," and that he had the answer right here in his hand. The operator could also hear a second woman in the house.

Seven minutes later, two uniformed officers arrived at the location, a mobile home park, and began to walk toward the subject residence when they saw a man in front of a residence point a gun at them, then turn and run into the house. The officers later stated they were too far away from the man to shoot at him when he pointed his gun. They called for backup. A field sergeant arrived and quickly requested that the Special Emergency Response Team (SERT) and the Crisis Negotiation Team respond to the location.

Dispatch learned from listening to the open phone line in the mobile home and fielding calls from neighbors and friends that the subject's wife and mother were in the residence with him and the mother was elderly and had difficulty walking. The subject was identified as Timothy Bucher.

Officers requested that TriMet send a bus to assist with evacuation of residents from mobile homes around the subject's residence. SERT officers and sergeants began to arrive and scout the containment positions around Mr. Bucher's residence. A few minutes later officers received word from dispatch that a caller said he had just talked with Mr. Bucher who said, there are "cops surrounding the place and he is going to shoot them." The caller also said Bucher was "off his meds" and did not usually act this way. Several attempts by the negotiation team personnel to get Bucher on the telephone failed because the residence telephone was off the hook.

At around 8:23 p.m., officers heard shots fired from Mr. Bucher's residence that sounded like handgun rounds. Two minutes later, another volley of shots was fired from inside the trailer. Two minutes after that, officers saw and heard more shots coming out of a window of Mr. Bucher's residence. Then two SERT armored vehicles arrived at the mobile home park.

Over the open line the dispatcher heard Mr. Bucher say that the police will shoot him and "death is on its way." A few minutes later, officers heard more shots coming from Mr. Bucher's trailer "going in the direction of officers." A caller from a nearby major street said a bullet just whizzed past her head. Bucher was audible over the phone line continuing to argue with his wife. Shortly afterward, Mr. Bucher's wife left the trailer and provided information to SERT supervisors that Bucher had a revolver and a .22 caliber rifle inside.

A few minutes later, Mr. Bucher's mother came out of the mobile home and approached PPB personnel. Bucher yelled that if any officers shot at her, he would kill them. The mother was walked to the Crisis Negotiation Team van where she confirmed that there was no one left in the mobile home other than Mr. Bucher and that he had a second rifle inside that she described as looking like "a war rifle."

With both family members now out of the trailer, SERT's tactical approach shifted. They no longer had to plan for a possible hostage rescue and focused their attention on the threat to unevacuated neighbors posed by Bucher's intermittent gunfire. Reports from neighbors confirmed that some of the bullets were passing through their trailer walls. As one SERT sergeant put it, the "focus is to get armor in front of the location to protect the officers, to have him focus on the armor so he stops shooting through the other trailers." Mr. Bucher's unpredictable gunfire had curtailed the evacuations.

Meanwhile, SERT finalized plans to launch gas into Bucher's mobile home and slowly pulled the two armored vehicles closer to the residence, with officers and a sergeant walking along beside each vehicle using it as cover. Sergeant Jim Darby supervised the group of officers in and around the smaller armored vehicle; a second SERT sergeant, Tom Forsyth, supervised the group with the larger armored vehicle.

As SERT armor approached the Bucher residence, officers were reminded over the air that many neighbors had not yet been evacuated and a SERT member broadcast to other SERT officers and supervisors at the scene, "I just want you to understand that if he comes outside again we are going to use deadly force to prevent him from going back in."[16] A lieutenant at the scene acknowledged the statement by saying, "Copy that."

[16] This comment reflected a brief discussion among SERT officers and supervisors over the radio suggesting that if Mr. Bucher came out of his house unarmed then changed his

While using the smaller armored vehicle "as a moving shield," Sgt. Darby heard more gunfire coming from the trailer. He was not sure where it was directed but recognized it as larger caliber than a .22. Sgt. Forsyth's team was also rolling into position near the mobile home. He said it was "obvious to me" from the distinctive crack of the gunfire that "we were taking fire from an assault rifle." Other officers saw some of those rounds strike the ground near the armored vehicles.

Sgt. Forsyth hesitated to signal officers to launch gas into Bucher's residence because the gas operators would have to leave cover to do so. Then Officer Chad Gradwahl, who was also walking along behind the larger armored vehicle, asked for authorization to apply cover fire to the window. Sgt. Forsyth authorized the use of cover fire to protect the officers about to launch gas. Officer Gradwahl fired several rounds from his rifle toward the top of the window and the wall just above the window. After a moment, Mr. Bucher fired four or five rounds from inside his trailer. Officer Gradwahl continued with a second volley of cover fire.

When cover fire commenced, a SERT officer standing alongside the armored vehicle launched one gas canister into a window on the side of the residence near the street. At the same time another SERT officer inside an armored vehicle had launched twelve smaller gas rounds into a second window. A third officer on another side of the residence launched four gas rounds into a third window of the residence. A fourth officer on another side of the residence launched two canisters into a window on that side. The simultaneous launching of gas into all four sides of the mobile home was intended to stop Mr. Bucher from continuing to fire bullets and to drive him to leave the residence.

Meanwhile, the smaller armored vehicle stopped in position a few yards from Mr. Bucher's front doorway. Sgt. Darby became concerned that the officers inside the armored vehicle were vulnerable to Bucher's rifle fire. He yelled at the officer in the turret on top of the armored vehicle to come down out of the turret and then, to protect the officers, he moved forward so he could see over the lower front hood of the vehicle. As his team members were putting on their gas masks, he illuminated the doorway with his flashlight and saw Mr. Bucher just inside the open doorway of the residence holding a rifle, pointing it at officers and appearing

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mind and went back in, it would be dangerous to allow him to regain access to his weapons. When SERT officers asked for direction on this issue before the wife and mother were out of the house, the Lieutenant at the scene had told them to allow Mr. Bucher to return inside. It is not clear from the recordings whether there was any further discussion from supervisors on this hypothetical question after the two women left the residence.

to manipulate the weapon in some fashion. Sgt. Darby fired four rounds at Mr. Bucher through the door frame which partially obscured him, but the sergeant could not tell if he hit Bucher. The gun barrel was lowered, then came back up. Sgt. Darby fired one more round.

He observed Bucher disappear briefly, then yell from inside, "I'm giving up. I'm giving up." This was broadcast to officers present just before Bucher walked out his front door, laid down on his front porch and said he couldn't move. While Bucher's hands were visible and empty, officers could not see if he had any weapons on him. Recently deployed gas coming out of the trailer further obscured the officers' view of Mr. Bucher. Supervisors approved sending the K9 in first before approaching to handcuff Mr. Bucher.

The dog was given a bite command and approached Mr. Bucher and bit him. Mr. Bucher immediately started fighting with the K9 punching it and putting it in a head lock. The arrest team moved in to handcuff Mr. Bucher. One of the arrest team officers was told by Sgt. Darby to use his Taser because Mr. Bucher was still wrestling with the dog and had his back to the approaching officers, and it was still unclear whether he had any weapons. An officer fired his Taser once at Mr. Bucher's back, causing Bucher to release the dog and give up. He was handcuffed without further incident and transported to a hospital.

Mr. Bucher fired a total of 14 rounds from his assault-style rifle. They were fired in many directions, some hitting trailers and two to three striking the armored vehicles. Some of the surrounding trailers had multiple bullet strikes penetrating their walls that appeared to have been fired from Mr. Bucher's assault rifle.

Sgt. Darby fired five rounds from his rifle, intending but failing to hit Mr. Bucher. Officer Gradwahl fired eleven rounds from his AR-15 rifle in cover fire mode, the authorized intent of which is to keep an armed subject from continuing to fire or threatening to fire a gun from a particular area of the building. Mr. Bucher was not wounded by these rounds. Four SERT officers fired gas into all sides of Mr. Bucher's trailer. The K9 was biting or trying to bite Mr. Bucher for several seconds. The Taser probes hit Mr. Bucher in the back and the officer activated the Taser for one standard five-second cycle.

Mr. Bucher had no direct gunshot wounds but a small fragment of a bullet jacket was removed from his arm at the hospital. He also sustained lacerations on his arms from the dog bites, but recovered from his wounds.

The matter was presented to a grand jury, which found that the use of deadly force was justified under criminal law.

The Police Review Board found that the shooting as well as the uses of less lethal force – the K9 and the Taser – were within policy and that all post-incident procedures were appropriate. The Review Board recommended that the SERT acting captain and two sergeants be given an organizational review debriefing regarding the early operational planning and supervision aspects of the incident. The Bureau Chief completed the debriefings with each of the three supervisors.

Timeline of Investigation and Review

5/24/2016	Date of Incident
6/7/2016	Grand Jury concluded
7/11/2016	Internal Affairs Investigation completed
7/19/2016	Training Division Review completed
8/9/2016	Commander's Findings completed
10/17/2016	Police Review Board
10/21/2016	Case closed

OIR Group Analysis

Tactical Issues

Use of Cover Fire

Officer Gradwahl's use of deadly force was in "cover fire" mode. The Bureau's definition of cover fire is firing a firearm to:

> *neutralize the use of deadly force. Cover fire is not intended to strike a subject but is meant only to prevent subjects from taking action against police or others or entering or occupying locations.*

Cover fire can be dangerous and must be used with extreme caution.

The use of cover fire in this incident appeared to be in line with this language. Sgt. Forsyth, who approved the use of cover fire, pointed out that this definition used to appear in the Bureau's use of force policy but was removed. Nevertheless, the tactic is still permitted and Training Division trains this definition. The Independent Police Review also noted cover fire, while an approved use of force, is no longer addressed in the Bureau's main use of force policy, Directive 1010.10, and should be reinstated. Currently, a definition for cover fire appears in the PPB policy manual but has the more ambiguous character of a general guideline rather than policy. It also no longer carries the "use with extreme caution" language.

RECOMMENDATION 16: The Bureau should reinstate its prior "cover fire" policy expressly in the Directives including the "use with extreme caution" language.

Use of Less Lethal Force

SERT operators used three "less lethal" weapons during the incident: gas, a K9 and a Taser. While three less lethal techniques are rarely used in overlapping succession, Mr. Bucher's demonstrated willingness to use firearms on the officers and his unknown physical state supported SERT's level of extreme caution. Bucher had stopped shooting and given up when his house filled with gas but then it became unclear whether he was attempting to cooperate or using a ruse to draw officers in while he was still able to access a weapon. His attempts to fight the K9 further fueled this concern.

A SERT operator fired his Taser at Mr. Bucher while he was still wrestling with the K9. At first blush, this may seem like a redundant use of less lethal weapons but it was reasonably well calibrated to end the struggle with the dog, keep Mr. Bucher from pulling a weapon out of his clothing, and hasten officers' efforts to secure Mr. Bucher. The Taser was activated for one automatic five-second cycle, the K9 handler called off the dog, and Mr. Bucher was immediately handcuffed.

Officer Safety and Equipment Concerns

The objective of the SERT plan to fire gas into the house was to get Mr. Bucher to stop shooting and come out of his residence, presumably through his front door. The subject's appearance at the front door, therefore, was not an unpredictable

outcome of launching gas into the residence. The SERT teams also knew before then that Bucher had an "assault-type" rifle, and not just a .22.[17]

The SERT plan called for using armored vehicles to provide cover and safety while allowing officers to get close enough to the house to effectively launch the gas into the home and ultimately apprehend Mr. Bucher. However, as the operation unfolded, Sgt. Darby decided suddenly that the officers in the armored vehicle were in danger and he came forward, partially leaving cover and exposing himself to gunfire from the chest up. He stated that at that moment he needed to be the one to stop the subject.

At this critical juncture in this incident, the two SERT sergeants, each with an armored vehicle team in similar positions working toward the same objective made strikingly different conclusions about their cover. Sgt. Darby, with the smaller armored vehicle, concluded on the spot that the officers inside the armor were vulnerable and must be protected by an officer outside the vehicle, namely himself. Sgt. Forsyth made statements later expressing his conclusion that the officer inside the armor was protected but that the officers outside the vehicle should not chance exposing themselves in order to launch gas until cover fire had suppressed Mr. Bucher's gunfire.

Sgt. Darby's use of deadly force was scrutinized and deemed in policy by the reviewing commander and the Police Review Board. His decision to move away from full cover and take a position where he eventually felt obliged to use deadly force was not scrutinized. According to the sergeant's statements, this decision was sudden and based on the realization that the subject had a high-powered weapon that could possibly penetrate the armored vehicle windows. The sergeant's sense of urgency was avoidable. The "confirmation" that the subject had an assault-type rifle had been broadcast 20 minutes earlier, before the armored vehicles had moved into place. The sergeants could have weighed and discussed concerns about the extent to which the vehicles were capable of protecting officers from Mr. Bucher's weapon earlier and adjusted the plan accordingly. They could have positioned the armored vehicle farther away or assigned another officer to provide lethal cover from a position of greater distance and safety.

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[17] The sergeant in charge of the other armored vehicle team a few yards away from Sgt. Darby's vehicle team stated that it had been "clarified and confirmed" that Mr. Bucher was firing an assault rifle about 20 minutes before Sgt. Darby decided his officers were in danger and fired at Bucher.

It is not clear from the record why the two sergeants reached different conclusions about the vulnerability of officers inside the armored vehicles to assault rifle fire and significantly different decisions about how best to address these vulnerabilities. It may signal a difference in assumptions about the capabilities of the armor, or an actual difference between the armor of one vehicle versus the other, or a fundamental difference in defensive doctrines. Any of these possibilities calls upon SERT and the Training Division to clarify the facts or make a policy decision that would put all supervisors facing similar challenges on the same page.

> RECOMMENDATION 17: The Bureau should ensure that its training message and any written protocols concerning the capabilities of its armored vehicles to provide cover against a variety of weapons is clear, consistent and fact-based.

Tactical Engagement by On-Scene Sergeant

Our prior reports have repeatedly addressed the role of on-scene sergeants, emphasizing the need for them to maintain a supervisory perspective and avoid tactical involvement, delegating these roles to officers in their command. The Bureau has responded to our frequent recommendations in this area with agreement and the assurance that current practice and training emphasizes this supervisory role for sergeants.

Here, Sgt. Darby was one of the two main SERT supervisors at the center of the scene. He was responsible for the inner perimeter, placing and commanding other SERT officers on one of the armed vehicle teams, and approving deployment of gas rounds launched into Mr. Bucher's trailer. Rather than maintaining that supervisory posture, however, at a critical juncture, Sgt. Darby took a position near the front of the armored vehicle, put himself in the lead for the likely confrontation of Mr. Bucher and partially left his hard cover.

While we can appreciate that the sergeant was concerned about the safety of the officers under his command, his primary concern should have been supervision of the incident, directing officers to positions of greatest safety and deploying resources as necessary. By taking an active hands-on part, he lost focus of this important role. Indeed, because he placed himself at the front of the action without having donned his gas mask (as his officers had) and was thus himself physically compromised by the gas that was deployed, he needed assistance from

an officer to move to safety, was briefly unable to perform his supervisorial tasks, and had to call upon a different officer to check on the welfare of other officers.

In addition, a few seconds before Sgt. Darby began shooting, he looked over and saw Officer Gradwahl shooting from behind the other armored vehicle but candidly stated that he did not know what the officer was shooting at. This was despite SERT radio broadcasts referring to cover fire and then the announcement "cover fire away," as Officer Gradwahl began to shoot. This may be simply a vivid reminder of how confusing an incident of this nature can be, especially once police rounds and gas canisters are fired. But it may also indicate that the sergeant had immersed himself so deeply into the action that he found it difficult to stand back and supervise the execution of the plan. Under these circumstances, it is inherently difficult to switch back and forth between actions as an operational officer and as a supervisor.

Despite the Bureau's past assurances regarding the importance of sergeants maintaining supervisory positions, neither the Training Division nor the reviewing commander identified or addressed these concerns with Sgt. Darby's tactical engagement.[18] In our Fifth Report, we recommended that the Bureau adopt a policy that reinforces the messages taught by training in the Sergeant's Academy and Critical Incident Management Class. We restate that recommendation here and add another recommendation to reinforce it.

> RECOMMENDATION 18: The Bureau should develop specific policy that instructs sergeants on the need to maintain their supervisory perspective and avoid tactical involvement in incidents when officers are available to perform those roles and should hold supervisors accountable for violating those directives.
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> RECOMMENDATION 19: Whenever a supervisor becomes tactically involved in a deadly force situation, the Commander's Memorandum, the Training Analysis, and the Review Board should all opine on whether such involvement was consistent with Bureau directives.

[18] This is in contrast to another case we review in this report, involving Mr. Hayes, where a sergeant who had been acting as an incident commander then engaged as a back-up rifle operator was subject to a formal debrief regarding his role.

Breadth of Review

This incident involved dozens of officers and supervisors, working both patrol and SERT assignments. The Bureau's review process was a multifaceted evaluation of uses of deadly force, use of gas, uses of a K9 and a Taser, planning and supervision of the operation by a captain and two sergeants and post-shooting procedures and preservation of evidence at the scene. The Commander's Memorandum raised a new issue that had not been identified by Internal Affairs or Training. The commander was critical of the SERT lieutenant's decision to initiate assignments without first seeking approval from the Critical Incident Commander, who was en route to the scene. Bureau policy does not directly address this issue.

The Police Review Board followed up on this point and recommended that the Critical Incident Commander and two of the sergeants receive debriefings on the issue from the Chief. Perhaps the greater value of the Commander's highlighting of ambiguities in the policy was to initiate a dialogue within the Bureau regarding command and control during critical incidents. We are informed that the Bureau further considered the issue and refined its policy concerning supervisory authority prior to the arrival of a Critical Incident Commander, issuing a clarification of that policy in March 2017. We are encouraged that the commander's comments helped promote this process despite the fact that the issue had not been previously identified in this case as an area of concern.

Timeliness of Interviews and Review Process

Both officers who used deadly force in this incident declined to be interviewed by detectives during the criminal phase of the investigation. Each testified at the grand jury proceedings. Each was interviewed by Internal Affairs three days after the incident. We have stated consistently in prior reports that this time lag between incident and first interview is not consistent with best practices.

Since the time of this incident, Portland has enacted a directive that requires an officer to submit to an administrative interview as soon as practicable, but no later than within 48 hours of the event unless the involved officer is physically incapacitated. We look forward to reporting on post shooting procedures that comply with this new standard.

Use of Air Support Surveillance Video

The day after the incident, the video footage recorded from the air support helicopter was shown to at least one roll call briefing group. Some of the officers and supervisors who witnessed the incident saw it before their interviews by Internal Affairs. We acknowledge that viewing such a video as a group at roll call can be highly beneficial to any discussion of tactics or officer safety and we generally encourage their use to provide real life examples for training purposes, but that purpose could have been equally well served by waiting a few days until after all witness employees had been interviewed. Showing such a video to some witnesses but not others undermines the communication restriction memos typically given to witness employees at the scene and would conflict with the Bureau's current policy prohibiting involved officers from viewing videos of an incident prior to being interviewed.

> RECOMMENDATION 20: The Bureau should continue to use surveillance footage of Bureau operations for training purposes but should develop handling procedures for recently recorded videos that ensure investigators have interviewed Bureau witnesses about the incident before videos are shown.

December 5, 2016 ◦ Steven Liffel

Late in the evening on the date of the incident, an anonymous call to 911 reported hearing shots fired in a residential neighborhood and gave a tentative address. An officer went to the area described, found nothing amiss and departed. Several minutes later, the officer was dispatched again based on another 911 call that reported shots fired and a woman appearing to hide outside near an apartment building.

The officer joined Officer Lawrence Keller and another officer and Sergeant John Holbrook at the scene and they approached the apartment building. The officer interviewed the woman outside when he arrived at the scene and was informed that the subject, her boyfriend Steven Liffel, was located in a nearby apartment building. He had woken her up and been threatening and incoherent and told her to leave. Soon after she went outside, she heard him come out yelling and heard gunshots. She believed he had shot at his own truck but gave no information about Liffel's firearms, drugs or mental health status. Officers shortly discovered the truck with apparent gunshot damage and heard yelling from Mr. Liffel's apartment.

The sergeant, who had taken command of the scene, requested more backup units and assigned positions to the officers at the scene behind cover. Sgt. Brian Hughes arrived and had a patrol vehicle with reinforced ballistic panels brought up close to the building to act as potential cover for officers. Officer Keller was assigned a position behind the reinforced police vehicle approximately 100 feet from Mr. Liffel's front door to provide lethal cover to other officers. Sgt. Holbrook directed officers to stop traffic around the apartment called Mr. Liffel's telephone six times, but the calls were not answered. Officers then heard a shot fired from the windows or doorway of the subject's apartment, heard a bullet pass overhead and concluded that Liffel was shooting in their direction.

After the shot was fired, Sgt. Holbrook called out the Special Emergency Response Team (SERT) and the Crisis Negotiation Team and instructed emergency communications to stop the commuter train outside the vicinity of the scene. Officers tried loud hailing Liffel using a patrol vehicle loudspeaker, also without a response.

Officers at the scene observed Mr. Liffel come out of his residence several times, yell at them, and then go back in. On one occasion, he appeared to attempt to

light toilet paper as part of a possible makeshift Molotov cocktail. On another, he had a pistol in his hand. On one or more occasions he yelled, "kill me" to officers and "come get me." Officers at the scene then heard another shot fired from inside the apartment. They began to evacuate nearby residents who had been told earlier to "shelter in place."

A few more shots at brief intervals came from Mr. Liffel's apartment though their direction was not clear to officers. Lieutenant Anthony Passadore arrived at the scene, was briefed by Sgt. Holbrook and took over as incident commander.

Other officers observed Mr. Liffel walking around his apartment with a revolver in his hand and yelling. Shortly thereafter, about an hour and 15 minutes after officers first arrived at the scene, Mr. Liffel stepped out his front door carrying a rifle and moved toward the street, ignoring commands to drop the gun. Officer Keller observed Liffel walking at "a steady pace with purpose" carrying the rifle at a "port arms ready position"[19] and inferred that Mr. Liffel was in a hunting mode.[20] Officer Keller fired one round, which struck Liffel in the hip. Liffel bent, tossed the rifle a short distance, then fell down and rolled on the ground and yelled, but did not fully respond to orders to crawl away from the rifle, which was nearby. He appeared to have an object in his right hand, came to rest on his stomach and tucked both hands under his stomach.

After the shooting, Lt. Passadore requested medical assistance. SERT officers arrived a few minutes after the shooting, formed an arrest plan and approached using an armored vehicle as protection with a beanbag shotgun and lethal cover. They handcuffed Mr. Liffel and called for medical personnel who were now staged nearby. Before they arrived less than a minute later, a SERT medic checked for signs of life and found none. The medical personnel pronounced Mr. Liffel dead at the scene 16 minutes after officers shot him.

The matter was presented to a grand jury, which found that the use of deadly force was justified. The Police Review Board found that the shooting was within policy and that all supervisory decisions and post-incident procedures were appropriate.

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[19] Held close to the front of the body with the barrel pointed generally upward.

[20] While Officer Keller did not report observing a change in the angle of the initially vertical barrel, another officer standing next to him did perceive that Mr. Liffel turned toward him and Officer Keller and begin to lower the rifle barrel toward them. Another officer reported seeing Mr. Liffel carry the rifle down the walkway at a 45-degree angle.

Timeline of Investigation and Review

12/5/2016	Date of Incident
1/18/2017	Grand Jury concluded
2/2/2017	Training Division Review completed
3/9/2017	Internal Affairs Investigation completed
4/3/2017	Commander's Findings completed
5/24/2017	Police Review Board
5/26/2017	Case Closed

OIR Group Analysis

Review and Tactical Issues

When Officer Keller was assigned to provide lethal cover with his rifle, another AR-15 operator was similarly assigned. Officer Keller's view of the front door was partly obstructed. He could only see the top few inches of the screen door and had to rely on broadcasts from another officer, positioned with the second AR-15 operator, who described the movements of Mr. Liffel until Liffel walked several feet down the walkway in front of his door where Officer Keller could see him. The other AR-15 officer had a clear view of the entire front door area. That officer stated to detectives he was about 75 yards away but he or his partner at this location were looking through binoculars and observed and broadcast Mr. Liffel's actions both inside and outside the apartment. He too saw the rifle with the barrel pointed up. He said he was prepared to shoot and that if the subject lowered the angle of the rifle, that would cross the "line in the sand" and he would have fired his AR-15. Officer Keller also stated that he was very concerned with the backdrop to his line of sight to the subject, should he have to shoot, because it contained a window of an apartment that was not yet confirmed evacuated. For this reason he intentionally fired his round "low." The obscured view of the doorway and the need to fire low potentially restricted his effectiveness in providing lethal cover.

There is no ideal terrain for the use of deadly force, but some positions found by other officers at the scene did not share these drawbacks. Additionally, the Bureau's newly acquired patrol vehicles with ballistic panels provide other options to strive for a flexible vantage point without compromising officer safety. In this case, however, the original cover vehicle for the assembled arrest team – for which Officer Keller was providing lethal cover – was parked facing north in the street that ran in front of Mr. Liffel's front door. The ballistic panel vehicle that was moved in for extra cover was placed parallel to the first vehicle. Officer Keller and other officers took a position on the west side of the reinforced vehicle; Liffel's apartment was on the east side. When Mr. Liffel came out his front door with a rifle, Officer Keller could not see him until he was a good way down his walkway walking toward the street. Thus, by the time Liffel did clear the side of a truck parked in his driveway and became visible to Officer Keller, he had only a few more feet to go before he might be standing in the street looking straight at Officer Keller and several colleagues, who would no longer be on the safe side of their cover. Officer Keller stated that he felt he only had a couple of seconds to determine whether to fire to defend himself and his team. This imminent prospect of officer vulnerability was concerning enough to the lieutenant who had just taken over as scene commander and was observing from behind Officer Keller that he stated he had instinctively begun to take his pistol out of its holster before realizing that, as incident commander, he should maintain a big picture and not focus on aiming his firearm at the subject.

In effect, when Mr. Liffel began to move out from the doorstep of his apartment for the first time, each of the two designated officers providing lethal cover for the rest of the many officers in the area were either too close and accessible (Officer Keller) or so far away (the other AR-15 operator) that he could not confirm that the object in Mr. Liffel's hand was a rifle without the aid of his partner on binoculars. With the benefit of hindsight,[21] it appears that the arrangement of officers and police vehicles was inflexible once the subject began to move forward out his front door.

The Training Division recognized this as an area of concern and discussed this scenario and the ways to use on-scene vehicles to maximize defensive

[21] Hindsight and the opportunity to consider a dynamic situation from many different angles are useful tools for training and debriefing purposes. Considering alternatives is not equivalent to rendering harsh judgments of decisions made in the field under time pressure. It is a hallmark of a learning institution that it is willing to try to extract tactical lessons from every critical incident.

opportunities in its 2018 in-service training. We encourage the Bureau to make this topic a standard part of tactical training.

Timing of SERT Activation

The sergeant in charge of the scene requested SERT activation after Mr. Liffel fired one round in the direction of officers. The parameters for requesting SERT are broad and great discretion is given to the incident commander. In this situation, due to efficient information gathering, the scene commander, Sgt. Holbrook, knew within a few minutes that the subject had a gun, had fired it outside of the apartment (hitting his truck), displayed mental distress and erratic behavior, did not respond to police communications, and was taunting police. Still, he did not call in SERT until about 35 minutes into the incident.

It is also notable that Sgt. Holbrook did not call to the scene an Enhanced Crisis intervention Team officer who would have extended training in communicating with subjects in mental health crisis and likely would have been available to respond more quickly than SERT or the Crisis Negotiation Team. Although there were early indications that Mr. Liffel was undergoing a mental health crisis, the sergeant elected to initiate communication himself, but he could not reach Mr. Liffel by telephone. Later, he delegated field officers to try getting through to Mr. Liffel by loudspeaker, also to no avail.

The Training Analysis deemed the sergeant's decision to activate SERT appropriate but did not address the timing of it or discuss the potential benefits of an earlier request.

Some of the tactical concerns we address above may have been alleviated by an earlier SERT response. SERT officers and supervisors do extensive training in just these types of scenarios and are the Bureau's recognized experts at tactical positioning and responding to barricaded subjects. They also bring specialized tools that can be crucial to successful resolution. SERT resources such as armored vehicles can also assist with the problem that proved so crucial in this incident -- finding hard cover close to the subject location. A more thorough discussion and examination of the timing of the decision to activate SERT by both Training and the Commander's Memorandum would have been a valuable component of a comprehensive review process.

RECOMMENDATION 21: The Bureau should evaluate the practicality of streamlining and standardizing the incident commander's decision factors for activating SERT.

Delay in Providing Medical Care

The delay in providing medical care to Mr. Liffel after he was shot raised important issues, some of which were examined at length by investigators. After being shot, Mr. Liffel rolled in pain and crawled a little before lying face down with his hands under his torso and the rifle close by on the ground. He lay still and did not respond to commands to crawl away from the rifle. The lieutenant who had taken over the scene just prior to the shooting, determined that it was not safe for patrol officers to approach the subject because he had previously used a handgun and may be concealing it under his torso. The lieutenant instructed officers to wait until SERT arrived to secure the subject. When SERT did so, medical personnel were allowed in and pronounced Mr. Liffel dead at the scene. A total of 16 minutes passed between the shooting of Mr. Liffel and his examination by medical personnel.

Training addressed the relatively late staging of medical personnel nearby and recommended a standardized medical staging procedure that would ensure that medical personnel are close by at the earliest reasonable stage.[22] While we agree that this is an important issue relevant to many critical incidents, the late staging of medical personnel in this case would only have been relevant had SERT been activated earlier. Sgt. Hughes had prepared a small team to approach Mr. Liffel with ballistic shields and a less lethal beanbag shotgun to secure him and get medical aid to him. But because of Mr. Liffel's proximity to his rifle and the fact that he had crawled forward but then hidden his hands, Lieutenant Passadore elected to take the cautious approach and wait for SERT instead of using field officers to try to secure the subject. When SERT personnel assembled, they quickly made a plan to approach and handcuff Mr. Liffel to address his medical needs with their own medically trained officers and ambulance personnel.

Thus, Training did not acknowledge the main reason for delayed medical attention in this particular incident – the decision to wait for SERT to assemble, make a plan and approach and secure Mr. Liffel so that medical could be allowed into the scene, particularly given the fact that the specialized team was not activated early in the incident. Mr. Liffel was responsive to some commands after

[22] The reviewing commander did not adopt Training's recommendation.

he was shot. He crawled forward as instructed but then stopped. As it turned out, the nature of Mr. Liffel's fatal injury – a severed major artery in the groin – may have rendered medical intervention at the scene ineffective, but the severity of his injury was not known until medical personnel could physically contact him.

> RECOMMENDATION 22: All of the Bureau's reviewers – Training, Commander, and Police Review Board – should consider all contributing causes in their analysis of a delay in providing medical care.

Timeliness of Interviews and Review Process

The investigation and review were appropriately broad-based, taking up important issues beyond the use of deadly force, including supervision and management of the active scene, post-shooting procedures, and medical care. This is in keeping with best practices and with the Bureau's current procedures.

The investigation and review were completed within the 180-day internal time limit agreed to by the Bureau. The interview of the officer who used deadly force, however, was not timely. Officer Keller was interviewed by Internal Affairs seven days after the shooting. Since he had declined to be interviewed by detectives at the scene, this was the first opportunity the Bureau had to learn about the officer's perceptions and thinking before he shot Mr. Liffel. This is too long for the Bureau to wait before interviewing the central involved officer. Since the time of this incident, Portland has enacted a procedural standard that requires an officer to submit to an internal affairs interview as soon as practicable but no later than 48 hours after an incident. We look forward to reporting on post-shooting procedures that comply with this new standard and, as discussed above, hope the Bureau will routinely obtain statements from involved officers before the end of their shifts.

February 9, 2017 ◦ Quanice Hayes

At 7:24, 7:26, and 7:35 in the morning, on a cold day with heavy rain, dispatch received three separate calls about crimes apparently involving the same suspect. The first was from a man who was the victim of an attempted carjacking. He was asleep in his car when the subject knocked on the window, displayed a gun, and eventually got into the car. The victim described the subject as a young black man, in his 20s, wearing a dark colored hoodie with the hood up and black jeans. The victim said the subject had held a gun to him that he described as a .45 that looked like a military gun, with desert camouflage. After a little more than 30 minutes, frustrated that the victim's car was out of gasoline, the subject got out of the car and walked away. The victim reported to the dispatcher that the subject put the gun into his waistband as he left.

The second call was from a woman who reported that her car had been broken into in a parking lot. She confronted the subject, who was still in her car, and he got out of the car and fled on foot. She described the subject as a young black man in his teens or early 20s, with shoulder-length dreadlocks wearing a blue or black shirt, jeans and a white belt, with a black rolling suitcase. As she was on the phone with dispatch, she walked around the corner to see the name of a cross-street, and again saw the subject.

The third call came from a woman who said there was a stranger banging on her door, who would have had to hop a fence to get into her backyard. She described the subject as a young black man in his teens or 20s, wearing a green or black hoodie, with the hood up, carrying something like a suitcase.

Two officers responding to this third call confronted the subject in the driveway at the caller's residence at around 7:45. Noting that he matched the description of the subject of the call – young black male with dreadlocks, dark hoodie, and jeans, standing over a suitcase – they ordered him to put his hands up, intending to detain him. The subject partially complied but continued dropping his hands while he talked to officers, claiming that he lived in the house. Officers communicated via radio that the subject was not complying, and additional officers began responding.

While one officer continued to detain the subject, the other went to the door of the residence to ask the 911 caller if she knew the subject. When she said "no," the subject took off running. As he began to run, officers stated that he grabbed at his

front waistband in a manner they associated with an effort to secure a weapon (as opposed to a move to pull up one's pants, for reasons they describe in detail). Believing that this likely was the subject wanted for the robbery who was armed with a handgun, officers made a decision not to pursue the subject around a blind corner and over a fence. Instead, they communicated with other officers about the subject's location and direction of travel, helping to focus the containment effort.

The Bureau of Emergency Communications dispatcher coordinated with the numerous responding officers, who were beginning to set a perimeter around the location of these three calls. Two sergeants – Kyle Nice and Jeffrey Helfrich – responded and assumed supervisory roles. Officers requested a K-9 officer and an AR-15 rifle operator.[23] A K-9 officer responded and began tracking the subject from the location he had last been seen. Officer Andrew Hearst responded to the request for an AR-15 operator and, with his partner, who armed himself with a less-lethal beanbag shotgun, joined the team tracking the subject. Sgt. Helfrich attached himself to the K-9 team and supervised the search, while Sgt. Nice assumed command of the overall incident.

The dog followed the subject's scent and eventually alerted to a backyard and a house in the area. Officers noticed signs that someone may have entered the house through a rear window and perhaps tried to kick in a nearby door and did some follow-up investigation relating to seemingly fresh footprints in the mud and a handprint on a railing. Sgt. Nice asked dispatch to contact the alarm company (for which there were signs at the house) to see if there had been prior alarms at the location that day and learned there had been none. Officers called all available phone numbers for the owners of the home to determine if the damage to the window and door was recent but could not reach anyone.

Officers held perimeter positions while the supervisors discussed whether to activate the Special Enforcement Response Team. They decided to hold off on that call and conduct some further investigation and tracking to see if they could determine whether the subject was in the house or had left the area.

As officers were examining the door into the basement at the rear of the house and pushing on it to determine if it had been breached, an audible alarm went off

[23] The K-9 is routinely used as a tool for tracking, searching, and the apprehension of at-large suspects. The AR-15 rifle fires high-velocity rounds with distinctive accuracy, giving officers an opportunity to address potential threats from a safer distance if necessary while minimizing the chances of hitting an unintended target. One disadvantage of an AR-15 rifle is it can be cumbersome when officers are on the move.

inside the house, and officers assumed it was the result of their activity. Because there had been no prior alarms, on-scene officers and supervisors reached the conclusion that the subject had not entered the house. Shortly thereafter, an officer who had moved toward the front of the house noticed a screen on the ground outside an open window that had previously been shut. As he looked around the area, he saw the subject crouching in the back of a narrow alcove between the house and garage.

The officer immediately gave the subject a command to put his hands in the air and alerted other officers in the area that he had located the target of their search as he drew his weapon and attempted to move to a less exposed position while still maintaining a view of the subject. The K-9 officer moved to the driveway at the front of the house, along with Officer Hearst, the less-lethal shotgun operator, Sgt. Helfrich, and one other officer. Sgt. Nice, who along with Lieutenant Richard Deland and Commander Bryan Parman had gathered around patrol vehicles across the street with several other officers, retrieved his AR-15 from his car and moved up to the side of Officer Hearst to serve as a secondary rifle operator. Other than Officer Hearst and Sgt. Nice, none of the other officers had firearms drawn. Two were providing less lethal options (K-9 and beanbag shotgun), Sgt. Helfrich was standing behind the others in a supervisory role, and the remaining officer was prepared to approach and handcuff the subject, so kept his hands free.

Officer Hearst had his rifle pointed at Mr. Hayes at the back of the alcove and had officers on either side of him. None of these officers in the driveway had positions of cover, as the angle of the alcove was such that maintaining visual contact with Mr. Hayes required them to be in the open driveway, but all describe their efforts to stay on the periphery of Mr. Hayes' lateral shooting range and to maintain some distance from the mouth of the alcove in accordance with their tactical training.

Because the alcove was too narrow to permit officers to safely go in toward the subject, the plan was to have Mr. Hayes come out into the driveway in a controlled manner, have him move to a prone position (lying flat on his stomach with his hands extended out), and then have a custody team approach and handcuff him.

Officer Hearst addressed him initially, instructing him to put his hands in the air, and, with greater specificity, told him that officers believed he was armed and that if he reached for his waistband, he would be shot. All of the witness officers describe Mr. Hayes as being somewhat – but not fully – compliant with officers'

commands. He put his hands up, but only part way, in a manner that officers took as a signal he was not 100% acquiescent but testing them and thinking about his options or formulating a plan.

The K-9 officer then began addressing Mr. Hayes, instructing him to get on his knees and then to crawl out of the alcove. Mr. Hayes immediately stood up and kept his hands partially up. The officer again instructed him to get on his knees and crawl out, and this second time he followed the instructions. However, when he was just out of the alcove at the edge of the driveway – about 10 or 15 feet away from the officers – he stopped crawling and raised his torso up while remaining on his knees.

The K-9 officer described this as unusual, because he said subjects generally want to demonstrate compliance when confronted with a barking dog and the fear of being bitten. Other officers also noted his failure to completely comply as unusual, because it would have been clear to Mr. Hayes that he was surrounded by officers and had no chance of escape, and because subjects in these circumstances generally give up and are taken into custody. In their interviews, all stated that it seemed Mr. Hayes understood the commands given to him, evidenced by his partial compliance and seeming reaction to what officers were saying.

Mr. Hayes then reached one hand behind his back, but then put it back up in the air. Officer Hearst described this as a moment that took his breath away, because he had nearly fired his weapon in response to this movement. A witness officer also observed this movement and remembered being surprised that no officer had shot in response. The K-9 officer – standing next to Officer Hearst – was preparing to release his dog with a command to bite the subject in response to Mr. Hayes' hand movement.

A second later, however, officers describe seeing Mr. Hayes drop his hand again – this time to the front of his waistband – and Officer Hearst fired his weapon three times. Mr. Hayes fell forward into the driveway and made no further movements.

Officers quickly assembled a custody team, retrieved a ballistic shield from one of the sergeants' cars, approached Mr. Hayes and secured him. Mr. Hayes had sustained three bullet wounds – two to the chest, and one to the forehead. Paramedics arrived but pronounced Mr. Hayes dead at the scene at around 9:30, nearly two hours after the first call relating to this incident.

There was a gun found within a few feet of Mr. Hayes' body, similar to the one described by the initial carjack victim. However, none of the officers on scene reported seeing the gun at any time prior to the shooting.

The District Attorney presented this case to the grand jury, which determined Officer Hearst's use of deadly force to be legally justified. The administrative review process culminated in a Police Review Board decision to find the shooting within policy, though the Board recommended a formal debrief for Sgt. Nice for stepping out of his supervisory role and assuming the role of secondary lethal cover.

Timeline of Investigation and Review

2/9/2017	Date of Incident
3/21/2017	Grand Jury concluded
4/4/2017	Training Division Review completed
4/14/2017	Internal Affairs Investigation completed
5/24/2017	Commander's Findings completed
6/29/2017	Police Review Board
7/3/2017	Case Closed

OIR Group Analysis

Tactical Considerations

Time, Distance, and Cover

We regularly emphasize the principle that tactics to improve officer safety also are less likely to leave officers in a vulnerable position from which they feel compelled to use deadly force. Here, the Bureau got many of these tactics "right" – officers who initially spotted Mr. Hayes did not get drawn into a risky foot pursuit but instead assisted in coordinating a containment and a K-9 track;

supervisors arrived on scene, coordinated resources, and made thoughtful, deliberative decisions; and officers maintained regular communication with each other and supervisors.

Nonetheless, officers did find themselves in a vulnerable position as they attempted to take Mr. Hayes into custody. They had strong reason to believe the subject they were confronting was armed but placed themselves in a position with no available cover. The Training Division Review addresses this, reached the conclusion that "rapidly [e]volving circumstances" left them with no options. Lt. Deland had directed officers to move a patrol vehicle with ballistic doors into a position at the end of the driveway to give officers a position to which to retreat if needed, but officers only used this option after the shooting, while determining whether Mr. Hayes continued to pose a threat.

What the Training analysis does not address is whether officers could have done anything to alter the rapidity with which this event unfolded. The tempo of events like this can become contagious. Officers had been searching for Mr. Hayes for nearly two hours, and once they had him literally cornered, it is not hard to understand that officers were eager to take him into custody. The role of the supervisors, however, is to manage that instinct and control the pace of the encounter.

Upon discovering Mr. Hayes crouched in the alcove, officers almost immediately began giving him commands to crawl out. An alternative would have been to hold Mr. Hayes at gunpoint in the alcove while conferring with each other about a plan for taking him into custody. The plan could have included moving a car into the driveway to create cover, or bringing the ballistic shields from the sergeants' cars as a source of protection, or backing out to the end of the driveway, where they could have still seen into the alcove but from a greater distance, out of easy range of the weapon they assumed the subject still possessed. These options were utilized after the shooting, when officers remained concerned about the subject's weapon; slowing the incident down could have given officers the opportunity to use these tools prior to the shooting. With the protection of cover, officers may have felt less vulnerable, and the less-lethal options might have been viewed as reasonable alternative responses to Mr. Hayes' lack of cooperation. Evaluation of these options and their applicability, including potential risks and downsides, would have made for a more thorough and constructive review.

As it was, the officers deploying less-lethal options were operating in a gray area because Mr. Hayes was partially following commands. Unambiguous defiance of

their orders that did not involve reaching for a weapon would have likely prompted use of the less-lethal tools available. For example, the K-9 officer was clear that if Mr. Hayes had simply refused to come out of the alcove or had taken off running, he would have unleashed the dog with a command to "take" the subject, but releasing the dog on a subject who was generally following instructions – if with some level of defiance – was not plainly justified. Similarly, the officer with the less-lethal shotgun said he would have fired had the subject tried to run, but the usefulness or appropriateness of a less-lethal deployment sooner than that was not obvious, and might have precipitated a use of deadly force if it caused Mr. Hayes to make a sudden movement. Both the less-lethal shotgun and the K-9 could have been deployed when Mr. Hayes dropped his hand to his waistband the first time, but he brought his hand back up quickly and then dropped it again, leading to the use of deadly force.

Clarity of Commands

Delaying the subject's move out of the alcove also would have given officers time to coordinate who would be giving him commands. While Officer Hearst and the K-9 officer recalled a clear demarcation between who was giving commands at which time, the statements from different witness officers painted a more confusing picture, with varying accounts of who was giving commands and when. Sgt. Nice stated that he gave the subject commands just before the shooting, and others reported hearing these commands from the sergeant, though Hearst and the K-9 officer did not mention this in their interviews. At a critical point, just moments before the shooting, the K-9 officer testified that he was the only one giving commands and that the subject rose to his knees on his own, not pursuant to any directions from officers. But a different witness officer gave an account to Detectives and to the grand jury that was confusing in light of all the other officers' recollections of these moments. He said the subject was arguing with officers over what may have been confusing orders to "keep his hands up" and to "crawl forward," noting that he couldn't crawl with his hands in the air. This officer remembered that someone had told the subject to "walk" forward on his knees.

Inconsistencies in the details of different witnesses' accounts of a critical incident are understandable and even anticipated, given the ways in which memory operates and the speed with which these events unfold. (Indeed, stories that match too closely can be suspect.) But these varying accounts point to what might have been a very significant issue. If officers on scene have differing views of what the subject is supposed to be doing in order to demonstrate compliance,

officers may develop different impressions of the subject's level of cooperation and have correspondingly different reactions. And if the subject is confused about officers' expectations, that creates another obvious set of problems. Here, the potential confusion the varying accounts portray might have been avoided had officers slowed their response and given themselves additional time to plan and coordinate. Unfortunately, these conflicting accounts were not explored in the administrative investigation and were not addressed in the Training Division Review.

All the witnesses were clear, however, that officers gave repeated warnings to Mr. Hayes, to the effect of: "We believe you have a weapon. If you reach for it, you will be shot." There are some potential downsides to this type of warning: It may commit an officer to a particular course of action, regardless of how the incident develops, or may encourage other officers on scene to fire, regardless of their own independent assessment. And it may signal to a suicidal person exactly what he or she needs to do to prompt the officer to fire.

The Bureau trains its officers that such a warning can be given when officers confront subjects, depending on the particular circumstances, but should be tailored to the nuances presented. Here, the officers had specific information about Mr. Hayes' possession of a handgun, and that he may be carrying it in his waistband. Further, when ordered to put his hands up, all the witness officers stated that Mr. Hayes did not put them all the way up, to signal surrender, but instead held them part way up, and raised and lowered them throughout the encounter.

While the warnings given to Mr. Hayes may have been appropriate in these circumstances, the Training Division should continue to weigh the tactical advantages and disadvantages of such explicit messages. Like the question of the need to immediately order Mr. Hayes out of the alcove and the confusion surrounding some of the specific commands that were given, the wisdom of these particular warnings should have been a point of discussion in the administrative review of this incident.

> RECOMMENDATION 23: The Training Division, Internal Affairs, and Commanders should identify, analyze and assess all of the tactical considerations surrounding a given incident, including the effectiveness of particular commands and warnings officers gave to the subject.

Action-Reaction Principle

The grand jury determined that Officer Hearst was legally justified in firing his weapon at Mr. Hayes. The relevant legal standard in adjudging potential criminality of deadly force is objective reasonableness, meaning that officers are authorized to use deadly force to protect themselves or others from what they reasonably believe to be a threat of death or serious injury.[24]

Under current criminal law, seeing a subject reach for what officers have reason to believe is a concealed weapon has often been considered sufficient to justify deadly force because of what is commonly known as the action-reaction principle. The principle, based on human physiology, holds that an initiator of an action has an advantage in a contest of time over a person who is trying to react to that action. As applied to police activity in this context, it means that an individual who draws a gun will be able to fire before the officer has time to perceive the action and react to it with deadly force. PPB officers receive training on this point in several contexts. One is to instruct officers that if they believe a subject is reaching for a weapon, it may be reasonable to use deadly force even before

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[24] While the Constitutional standard instructs that the use of deadly force be considered through the prism of "objectively reasonable," PPB's use of force policy places additional requirements on its police officers. For example, the Directives requires the use of disengagement and de-escalation:

> 1.1. Members shall use disengagement and de-escalation techniques, when time and circumstances reasonably permit. De-escalation techniques provide members the opportunity to stabilize the scene or reduce the necessity for or intensity of force so that more time, options and resources are available to resolve the confrontation. Members shall take proactive steps to eliminate the immediacy of the threat, establish control and minimize the need for force.
>
> 1.1.1. De-escalation techniques include, but are not limited to: 1) using verbal techniques to calm an agitated subject and promote rational decision making; 2) allowing the subject appropriate time to respond to direction; 3) communicating with the subject from a safe position using verbal persuasion, advisements, or warnings; 4) decreasing exposure to a potential threat by using distance, cover, or concealment; 5) placing barriers between an uncooperative subject and an officer; 6) ensuring there are an appropriate number of members on scene; 7) containing a threat; 8) moving to a safer position; and 9) avoiding physical confrontation, unless immediately necessary.

seeing the weapon, because it may be too late if they wait for visual confirmation before firing.

Officer Hearst referred several times to the action reaction doctrine in his testimony before the grand jury. He also stated, "[w]ith all of the information I knew up to that moment, there was no doubt in my mind he had a gun."

This statement raises the all-important context of the shooting – what officers knew or believed about the subject and what alternative tactics that knowledge should suggest. One pitfall of law enforcement's reliance on the action-reaction principle is that it can easily be misconstrued by officers who may believe they have a mandate to shoot anyone holding a gun, or someone who might have a gun and makes a sudden movement, regardless of other tactical alternatives or threat assessment. We have seen in some agencies where "action-reaction" has become the justification for almost any use of deadly force. Therefore, it is important for reviewers to unwind these situations and consider the totality of the circumstances and the specific threat to which officers were responding. Most significantly, it is critical for Bureau reviewers to determine, consistent with the Bureau's disengagement and de-escalation dictates as set out in the Directives, whether officers and on-scene supervisors did all they could to slow the incident down, keep themselves safe in positions of cover, develop a plan where each officer has a clear understanding of his or her role, communicate effectively and clearly with the subject, and not place themselves in a vulnerable situation where they felt constrained to use deadly force.

When evaluating incidents where the action-reaction principle is cited, we employ three basic guidelines:

- The action-reaction principle may be a useful cautionary component of training but it should not be applied as a catch-all defense to every lethal force decision that turns out to be misinformed or misguided.
- The implications of this principle are not to justify using deadly force but instruct officers of their own physical limitations and the need to do all they can to keep themselves from a position of vulnerability and where deadly force then ends up being the outcome.
- There are often available engagement tactics that reduce or eliminate the need to use deadly force when a subject makes a movement suggesting a reach for a weapon.

An analysis of this incident compelled by these precepts produces a more exacting evaluation of the events. We do not suggest that the Bureau engage in exotic or newfangled theorizing but rather insist on some fundamental principles that have guided force training for decades: Cover, Time and Distance are the vital tools that police officers must employ whenever possible to slow the situation down, reduce danger to themselves and others, and place greater control of the outcome in the hands of the officers.

In fact, to the Bureau's credit, new officers receive precisely this message at the Bureau's Advanced Academy. In the classroom, the mat room, and in shooting scenarios, trainers convey the principle, "action beats reaction so do something to change that" by, for example, moving to cover or ordering the subject into a disadvantageous position.

Most significantly, then, it is similarly critical for reviewers of these events to determine whether officers and on-scene supervisors did all they could to demonstrate their implementation of this training. Unfortunately, in this case, none of the Bureau's review mechanisms sufficiently explored the question of whether the on-scene officers and supervisors performed consistently with the training that accompanies the action-reaction principle, and instead reached the fatalistic conclusion that Mr. Hayes' actions drove the outcome. As we discussed above, a more thorough and constructive review would have assessed questions about how personnel might have altered the tempo of their response, allowing them to weigh options for providing cover, to better coordinate commands, and to consider safer ways to take Mr. Hayes into custody.

In this case, we raise the following questions about whether the on-scene officers performed consistent with the training accompanying the action-reaction principle:

- Were there other options that officers could have deployed for cover (as they did after the shooting) such as utilizing the patrol car with ballistic doors that was on scene?
- After redesigning the scene to provide cover could the Bureau have slowed the incident down to consider other tactical options?
- Would slowing down the incident have provided an opportunity to better plan who was going to give the commands to order Mr. Hayes out, what those commands would be, and when they would occur?

The Bureau's review process did not sufficiently address these critical issues. When analyzing Bureau performance, it is imperative, consistent with the Bureau's de-escalation policy, to conduct a more exacting review.

> RECOMMENDATION 24: The Bureau and Police Review Board should ensure that officer-involved shooting reviews do not begin and end with a citation to the action-reaction principle but must critically assess other tactical options that might have driven a different result.

Supervisory Issues

Sgt. Nice was acting as the incident commander during the search for Mr. Hayes. As attention focused on the house outside of which officers ultimately found him, however, he believed that the situation called for a secondary AR-15 operator, and he armed himself with his rifle. He put it away for a time during which he was conferring with Lt. Deland and Commander Parman, but then took it out of his car again and stood near Officer Hearst while they confronted the subject. We have frequently commented in prior reports about the disadvantages of sergeants assuming tactical roles during a critical incident. Training, the Commander, and the Police Review Board, all recognized that Sgt. Nice should have remained the incident commander and not inserted himself into the role as secondary lethal cover. This became the subject of a formal debrief.

Grand Jury Concerns

The District Attorney convened a special session of the grand jury the day after the shooting to capture the testimony of the victim of the incident that initiated officers' search for Mr. Hayes. His testimony came five weeks before the remainder of the grand jury proceedings because the prosecutor was not certain the witness would still be living in the area at the time the criminal investigation was complete.

The witness identified Mr. Hayes as the person who robbed him at gunpoint, threatened his life, and held him hostage in his car for an extended period. He described a sequence of events that unfolded during the time Mr. Hayes was in his car, and identified items stolen from him that were later found in Mr. Hayes' possession. The prosecutor asked him to describe the gun Mr. Hayes brandished and at the end of his detailed response, which included him recounting how the

gun was pointed at his face, he said, “I’m glad he’s dead. It still bothers me because the way everything happened, but I’m glad he’s dead.” With that statement, the prosecutor concluded the proceedings.

This highly prejudicial statement, while not elicited by the prosecuting attorney, should have prompted the prosecutor to request it be stricken and to instruct the jury to disregard it.

Timing of Interviews

This incident happened during the period of time after the City had eliminated the so-called “48-hour rule” from its contract with PPB officers (and before it was effectively reinstated after intervention from the District Attorney and then again eliminated by action of City Council). In this case, Internal Affairs investigators interviewed Officer Hearst – a compelled administrative interview – about 25 hours after the shooting incident. Officer Hearst declined to give a voluntary statement to Detectives conducting the criminal investigation but did testify before the grand jury 47 days later.

February 9, 2017 ◦ Don Perkins

In the evening on the date of the incident, Don Perkins called 911 twice and reported that he had taken 30 pills and would take 30 more if he could not contact his doctor. He said, "I'm killing myself," and refused to answer questions about his location. This and other remarks caused the Bureau of Emergency Communications to deem this a suicide call and to dispatch officers as a priority welfare check. Officer Roger Walsh was assigned to the call and requested that an Enhanced Crisis Intervention Team (ECIT) officer be assigned as well. Officer Bradley Clark heard the request and indicated that he was ECIT trained and would respond. Emergency Communications provided a rough location for the caller based on the GPS signal from the cell phone.

The officers were unable to find anyone in the vicinity of the location and requested that dispatch "ping" the cell phone for a more precise location. After continuing their search a few blocks away, they received an updated location based on the ping results and drove there. After a few minutes of searching in the new area, the officers approached a parked van with fogged windows and called out for Mr. Perkins.

When there was no response, the officers opened the back door of the van. Mr. Perkins was sitting in the back of the van with a pill bottle and pills on the floor near him and nothing in his hands. Officer Clark told Mr. Perkins they were concerned about the pills and wanted to get him some help, then moved to the van's side door, which Officer Walsh had just opened. As Officer Walsh looked into the van he saw a black object in Mr. Perkins' hand and heard a metallic click, which he associated with firearms. Officer Clark likewise heard the click and shared his partner's concern.

Both officers unholstered their guns and quickly backed away to crouch behind the back of Officer Clark's patrol car parked a few yards away. Officer Clark retrieved his AR-15 rifle while Officer Walsh broadcast that they had found Mr. Perkins and that he might have a gun. Dispatch began the process to stage medical personnel nearby. The officers requested another rifle operator and another Enhanced Crisis Intervention Team officer.

Mr. Perkins opened the side door of the van and threw a small object out that looked like a pill bottle then tossed another object, black in color, and sat in the door screaming at the officers that he had just thrown a gun out and that the

officers should approach him. They remained behind the cover of the patrol car and tried to talk to Mr. Perkins, whereby Mr. Perkins began yelling, "It's your call. Shoot me, bitch. Kill me. Come get me," and "Everybody here don't go for the gun."

Officer Clark instructed Mr. Perkins to show his hands and walk back to them. Mr. Perkins would not and yelled profanities. The officers had concluded that the black colored object that Mr. Perkins threw out of the van was a gun and told Mr. Perkins not to reach for it or he would be shot. Mr. Perkins said he had another gun in the van. The officers agreed with each other that they would fire if Mr. Perkins attempted to pick up the gun on the ground.

A third officer arrived who had heard the incident developing over the radio and joined Clark and Walsh. Sergeant Jerry Cioeta arrived and walked up to the three officers behind the patrol car. The sergeant instructed the third officer to get a beanbag shotgun from her patrol car. The sergeant observed a black object in the grass three or four feet from where Mr. Perkins was sitting facing out of the side door of his van. Mr. Perkins bent down and reached out toward the black object. Officer Clark fired one round from his rifle and Officer Walsh, who had begun to pull the trigger of his pistol, desisted, hearing the round from the rifle.

Mr. Perkins jumped to a nearby tree and hid behind it, yelling at officers to shoot him. It was not clear to the officers or the sergeant whether the rifle round had hit Mr. Perkins or whether he had retrieved his weapon from the ground. He then reached down to the grass for the black object again and Officers Clark and Walsh both fired rapidly. Officer Clark fired another three rounds from his AR-15 rifle and Officer Walsh fired his service pistol six times. They wounded Mr. Perkins in the abdomen and the right elbow. The shooting occurred approximately nine minutes after the officers first made contact with Mr. Perkins. The officers and Sgt. Cioeta spent this time retrieving a beanbag shotgun from a patrol vehicle, calling for additional back up including another rifle operator and another ECIT officer, observing the actions of Mr. Perkins and considering what level of threat he posed.

Mr. Perkins moved out of sight behind the front of the van. The sergeant called for the Special Emergency Response Team (SERT) and the Crisis Negotiation Team to come to the scene. Officer Clark yelled to Mr. Perkins who said he was hurt. He complied with commands to come out in the street with his hands up. Mr. Perkins followed other commands and was handcuffed without further

incident. Officers observed a black metal pistol lying on the grass by the open side door of the van.

Medical assistance had been staged nearby, but before the ambulance arrived, the sergeant observed Mr. Perkins' wounds in his abdomen and elbow. He put a tourniquet around Mr. Perkins' wounded arm.

Mr. Perkins made statements in the ambulance on the way to the hospital that he had a "BB gun" that looked like a real gun and pointed it at the police when they opened the door to his van so that they would go away. He said he later threw a pill bottle and the gun out of the van so that the police would know it was a fake gun, but also told the officers to "go ahead and shoot" him. He stated that he realized that when he picked up the gun the police would shoot him and that is what he desired at the time.

Mr. Perkins recovered from his wounds. The object Mr. Perkins threw was later identified as a BB gun made to replicate a handgun.

The matter was presented to a grand jury, which found that the use of deadly force was justified under criminal law.

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

Timeline of Investigation and Review

2/9/2017	Date of Incident
3/15/2017	Grand Jury concluded
4/3/2017	Training Division Review completed
3/21/2017	Internal Affairs Investigation completed
5/11/2017	Commander's Findings completed
6/21/2017	Police Review Board
6/27/2017	Case Closed

OIR Group Analysis

Consideration of Tactical Options

When officers opened fire on Mr. Perkins, it was the result of a decision based on the accumulated evidence that Perkins had thrown what resembled a gun on the ground, that he asserted it was a gun, that he was belligerent and taunted them to kill him yet tried to get them to leave cover and approach him. The officers had a conversation in which they had concluded that, if Mr. Perkins tried to pick up the presumed thrown gun, they would shoot to defend themselves. They later stated that they even considered the safety to possible bystanders provided by the backstop area behind Mr. Perkins.

Both the Training Analysis and the Police Review Board concluded that the officers' use of force was justified under the circumstances. Training, however, added the following:

> *Mr. Perkins… due to his suicidal mind set and his unwillingness or inability to de-escalate he left the officers with no other option than to fire their weapons to stop him as a threat when he reached for the gun.*

Unfortunately, Training did not discuss or analyze other alternatives that the officers might have considered. Indeed, implicit in the officers' quick though rational and deliberate process was the consideration of other options. Even Officer Walsh's release of pressure on his trigger just after his partner fired his rifle shows a trained field officer considering options in real time. This makes sense because there are virtually always other options to consider.

Here, for example neither the Training Division Review nor the Commander's Memorandum addressed the following possibilities, including some that look back to the circumstances that led up to the incident:

- Officers perhaps could have found improved cover using other patrol cars, ballistic shields or trees in the area. This may in turn have allowed the officers to delay use of firearms, if only for a very short time.

- Officers might have considered activating SERT and the Crisis Negotiation Team and attempted to hold Mr. Perkins in place until a

negotiating team arrived. The incident documentation does not reflect any consideration of activating SERT before shots were fired.

- If dispatch had asked Mr. Perkins whether he had any weapons, officers might have been better prepared for the scenario they ultimately encountered.[25] Even if less lethal weapons, ballistic shields or other defensive equipment were not available on scene, this consideration of the early phase of the incident might stimulate consideration by Bureau leadership of whether they should be more widely available.

For the Training division to intone the formula of "no alternatives," especially in circumstances where officers anticipate encountering a suicidal subject, is inaccurate and counter-productive. Incidents where persons in mental crisis act belligerent and attempt to taunt and provoke officers into killing them have become all too common. They are rightly perceived as potentially dangerous to peace officers, but they also raise a question fundamental to engagement with determined subjects: what can officers do to influence the outcome rather than let the subject determine the outcome? We considered these questions in detail in our Fourth Report.

Acknowledging that there are always alternative scenarios that are worth considering, even if it may move the discussion into the realm of the hypothetical, does not undermine a finding of justifiable use of force. But wrapping up a Training analysis with "he left the officers no other option than to fire their weapons" effectively ends any further discussion. It relegates critical incidents that receive that verdict from the training experts useless for training purposes and reinforces tactical thinking about inevitable outcomes that discourage innovation and creativity.

It is important to acknowledge that these officers and their sergeant did make attempts at de-escalation, including retreating from the van and taking cover; calling for another ECIT officer and trying to communicate with Mr. Perkins; retrieving a less lethal weapon; declining to fire upon hearing a partner fire a round. Training nevertheless implied that these attempts at de-escalation were a failure because "they were not reciprocated by Mr. Perkins." This view relegates de-escalation to just one of a number of techniques that field officers may pull out of their quiver when circumstances are favorable. It should instead be viewed as

[25] While Mr. Perkins was belligerent, uncooperative and hung up abruptly when questioned about his location during both 911 calls that he made, dispatch operators possibly had the opportunity to try a new topic and ask him about weapons. It is impossible to know whether he would have answered the question.

an evolving framework of analysis that helps law enforcement agencies improve. Every critical incident should be reviewed as a learning opportunity to keep stimulating that analysis and improving opportunities for effective de-escalation.

> RECOMMENDATION 25: The Bureau's Training Division should eliminate the phrase "left the officers with no other option…" from their analyses.

Delay in Locating 911 Caller

Officers encountered a significant delay in locating Mr. Perkins. They discovered him in a van 45 minutes after he first made a suicidal 911 call. They had been searching in the general area for 35 minutes. Because he had called 911 from a cell phone without providing his exact location, officers originally only knew where he was within a 300-yard radius. This circumstance has become very common because of the ubiquity of cell phones. Officers are encountering the extra challenge of finding the caller's locale because cell phones cannot be traced as precisely as land lines. Nevertheless, the "pinging" process – triangulating the location of the cell phone from nearby cell broadcasting towers – can narrow down the possible locations to a 25-yard radius and significantly shorten the search process for officers in the field. Initiating this procedure immediately after the Bureau of Emergency Communications receives any urgent call with an unknown address would allow dispatchers to guide officers in a more timely and precise way.

> RECOMMENDATION 26: The Police Bureau should work with the City to evaluate the practicality of procedures that would require the Bureau of Emergency Communications to initiate locating technology early in the dispatch/assignment process so that officers can expend less time searching for 911 callers who raise a credible threat of suicide or other source of imminent death or injury.

Timeliness of Interviews and Review Process

The investigation and review process were completed well within the 180-day internal time limit agreed to by the Bureau. The great majority of the process up to and including the Commander's review and findings was completed in a commendably short three months.

Both officers who used deadly force in this incident declined to be interviewed by detectives during the criminal phase of the investigation. Each testified at the grand jury proceedings. Each was interviewed by Internal Affairs two days after the incident. We have stated consistently in prior reports that this time lag between incident and first interview is too long, especially when the Bureau has had no previous opportunity to obtain a statement from the officers who used deadly force. It did, however, comply with the Bureau's standard procedures at the time of the incident. Since the time of this incident, Portland has enacted a procedural standard that requires an officer to submit to an internal affairs interview "as soon as practicable" after an incident. We look forward to reporting on post shooting procedures that implement this new standard.

May 10, 2017 ◦ Terrell Johnson

Just before 7:00 in the evening, a woman called 911 from a MAX platform to report that an individual later identified as Terrell Johnson had approached her and her companions as they waited for their train to ask for a cigarette. They told him "no" and then, "out of nowhere," he began chasing their 17-year-old neighbor who had just gotten off the train and stopped to talk to them. They described the subject as a white man,[26] with a hooded sweatshirt and knit cap, who appeared to be homeless. When the dispatcher asked if the subject had any weapons, the caller responded that she did not see any.

The young man who was chased off the platform later reported that Mr. Johnson had pulled a knife on him. He was able to run away from the subject, then called his father and ran the short distance home, where he retrieved a kitchen knife and gathered some friends before returning to the area and confronting Mr. Johnson. They had a brief standoff with their knives drawn and exchanged words before the boy's father arrived and, as tempers were cooling, they saw the police arriving in the area. The young man, his father, and his friends all left abruptly and returned home without officers even noticing them. Officers only put together this piece of the story later, when witnesses came forward after the shooting.

Officer Samson Ajir and his brother, a Clackamas County Sheriff's Deputy,[27] picked up the call.[28] Both are assigned to Transit Division and regularly work together as partners. The initial call voiced to Officer Ajir made no mention of any weapons, but when he read the call on the in-car computer, it said "now weaps." Officer Ajir believed this was strange, vague, and somewhat ambiguous

[26] Mr. Johnson was in fact biracial, with an African-American mother and white father.

[27] Transit Division is staffed by officers from various local law enforcement agencies throughout Multnomah, Washington, and Clackamas Counties – all the areas serviced by TriMet.

[28] Because officers assigned to Transit Division regularly move between precincts and jurisdictions, calls are dispatched via text message to a Bureau-issued cell phone. The text provides a brief summary of the call and the jurisdiction in which it originated. Officers can then switch to the radio net for that jurisdiction to get further details and updates on the call. Within the City of Portland or Gresham, officers can get information on a call via their in-car computer system. In all other cities and county areas serviced by TriMet, officers must use the radio to voice in their responses because they do not share the same Computer Assisted Dispatch system.

because it is not how information about weapons would normally be communicated and contained no detail about any particular type of weapon. Officer Ajir stated he did not have time to request further information about weapons during the short drive to the location of the call but interpreted the information to mean that the subject had a weapon of some sort.

A West Linn Police Department officer also assigned to Transit was close by and attached himself to the call as an assist unit. He was the first to arrive on scene and was quickly able to identify the subject based on the description provided by the original caller. He approached Mr. Johnson, who at the time was talking to another individual, and began questioning him about the alleged threatening behavior. He asked Mr. Johnson whether he had any weapons, and the subject told him he had a knife in his pocket. The West Linn officer cautioned him not to reach for that knife. He asked Mr. Johnson if he could pat him down and take the knife, and he refused. The officer said Johnson seemed fidgety and kept looking over his shoulder as if planning to run, so the officer asked him to sit down, but he refused. The officer planned to wait until Officer Ajir and his partner arrived before making physical contact with Mr. Johnson.

When Officer Ajir and his brother reached the location, within minutes of the West Linn officer's initial contact with Mr. Johnson, the subject took off running almost as soon as the two exited their patrol car. As he got out of the car, Officer Ajir heard the West Linn officer say, "warrant," and saw the West Linn officer begin to chase the subject. Officer Ajir joined the chase as the Clackamas deputy went back to the car with the plan to drive ahead and cut off the subject's path. The officers did not communicate with each other about this plan, and the West Linn officer did not tell Officer Ajir that the subject had a knife.

Officer Ajir is a fit and experienced runner, and his plan was to chase the subject until he was tired and eventually gave up. He ran faster than the West Linn officer, and quickly got out ahead, without any knowledge of specifically where his partners were. As the West Linn officer fell behind the chase, he considered trying to run toward the deputy in the car so he could ride with him but then he saw the foot chase change course and head into an area of tracks where a car would not be able to go, so he continued running in that direction. He reported seeing Officer Ajir catching up to the subject, close enough to grab hold of him, but then lost sight of them. When he caught up again, he saw that Mr. Johnson had turned and was facing Officer Ajir with a knife in his hand. The West Linn officer was still 60-70 feet away. The Clackamas deputy was navigating the terrain and monitoring the subject's course, trying to find a way to cut him off.

He could see the subject and the pursuing officers, but had an obstructed view and was approximately 150 feet away when he heard the first gunshot. He quickly got out of his car and ran to assist.

The chase crossed uneven terrain and required Officer Ajir to hop over the tracks and curbs. As Mr. Johnson slowed to a stop, Officer Ajir closed the distance, thinking that he was going to surrender. He was surprised when the subject turned around with a knife in his hand, slashing at the officer.[29] He unholstered his weapon as he tried to back up to distance himself from the subject, who at the time was only around seven or eight feet from him. As he moved back, his heel hit a curb and he started to fall backward. According to Officer Ajir's statement, he fired one shot as he was falling, and the subject continued to slash out and move toward him. From the ground,[30] Officer Ajir fired three more rounds at Mr. Johnson, who fell forward.

This incident, including the shooting, was captured on TriMet video, which is generally consistent with officers' accounts.

Mr. Johnson fell on top of the knife, and officers were concerned he may try to use it as they approached to handcuff him. They called for a code-3 medical response, and then requested a ballistic shield to use as a barrier when they contacted him. Within minutes, other arriving officers had secured Mr. Johnson, and two Clackamas County deputies were administering emergency first aid until paramedics arrived. The paramedics declared Mr. Johnson deceased at 7:21, approximately six minutes after Officer Ajir had broadcast the shooting. He was struck three times, in the chest, side, and hip or buttocks. The fourth round appears to have passed through Mr. Johnson's jacket without striking him and was not recovered.

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[29] The knife is what is referred to as a utility knife or box cutter. Officer Ajir recognized the knife as what he said is referred to on the streets as a "slasher."

[30] Officer Ajir remembered his buttocks hitting the curb, and said he used his left hand and a rocking motion to quickly push himself back up to his feet, while simultaneously firing at the subject. The video pretty clearly depicts Officer Ajir being on the ground at the time he fires all rounds, providing an interesting example of the ways in which normal human memory may differ from recorded video in significant – but not necessarily nefarious– ways.

Timeline of Investigation and Review

5/10/2017	Date of Incident
6/22/2017	Grand Jury concluded
8/14/2017	Internal Affairs Investigation completed
8/25/2017	Training Division Review completed
10/16/2017	Commander's Findings completed
12/18/2017	Police Review Board
12/20/2017	Case Closed

OIR Group Analysis

Tactical Issues: Foot Pursuits

When a person runs from officers attempting to detain him, the officers' instinctive reaction may be to immediately give chase and catch the subject at all costs. This common scenario, however, creates untenable safety risks to officers, the public, and subjects being pursued.

The dynamic of most foot pursuits is inherently unsafe for the officer. Some of the factors are simple ones. For instance, a long foot pursuit can place physical strains on officers that compromise their effectiveness in various ways. Here, Officer Ajir's plan was to chase the subject until he was tired enough to surrender. After about 200 yards at what he described as a sprint, though, while Mr. Johnson may have been tired and therefore ready to turn around and fight, the officer was also "gassed." It is impossible to know exactly how that may have affected the officer's agility in backpedaling over difficult terrain, but fatigue almost certainly played some factor.

Other potential problems arise from the reality that the subject determines the path of the pursuit, and can therefore readily establish a tactical advantage through maneuvers that cause the officer to lose visual contact and become more susceptible to sudden aggression. Awareness of this danger heightens officer

adrenaline and perception of threat in obvious ways – thereby increasing the likelihood that ambiguous gestures (such as turning or grabbing at a waistband or carrying an object) will be interpreted as lethal aggression. When it turns out that the person being chased was simply trying to escape, or was not armed at all, this gap in perception can have devastating consequences.

It is important for officers and members of the public to remember that the decision to not engage in a foot pursuit does not equate to letting the "bad guy" go. Rather, it is an acknowledgment that usually there are safer, smarter ways to apprehend suspects than chasing them down. As well-regarded policies and accompanying training emphasize, an officer who is chasing a suspect and properly communicating can continue to follow without closing the distance unsafely. Coordinating the response of fellow officers and establishing a containment are regarded by tactical experts as more sound and effective approaches.

Guidance to police agencies and their officers on when and how to pursue has evolved over the years, and many agencies – including PPB – have adopted comprehensive foot pursuit policies in an attempt to provide guidance to officers to mitigate these risks. The Bureau foot pursuit policy provides guidance to officers on the dangers of foot pursuits, factors to consider in deciding whether to initiate or continue a pursuit, and how to balance officer safety considerations with the objective of apprehending a subject.

The effectiveness of PPB policy and training on these points was evident in another incident we discuss in this report, where officers who initially confronted Mr. Hayes more than an hour before the eventual shooting decided not to pursue him because of the inherent risks. Here, unfortunately, there were gaps between the dictates of PPB policy and Officer Ajir's performance and disparities in the application or interpretation of the policy by Training and the Bureau reviewers.

Specifically relevant here, the directive states:

> Sworn Member Responsibilities (630.15)
>
> a. Once the foot pursuit has been initiated, the pursuing sworn member should notify BOEC and attempt to broadcast the following information:
>
> 1. The suspect's direction of travel.
> 2. Whether the suspect is armed, if known.
> 3. Number of fleeing suspects.
> 4. The reason for the pursuit.

5. If known, the identification of the suspect, or a physical description.

b. Generally, the pursuing sworn member should not attempt to overtake the fleeing suspect but keep the suspect in sight until sufficient cover is available to take him/her into custody.

The following are techniques to consider:

1. Following and maintaining a safe distance.
2. Paralleling the suspect.
3. Cover/contact pursuits (two sworn members).
4. Following a different route then the suspect (i.e., wide corners).
5. Using Available cover (i.e., parked cars).

c. The primary sworn member should attempt to immediately coordinate with secondary sworn members to establish a perimeter in the area to contain the suspect. Secondary sworn members may assist with the coordination if the primary sworn member is unable to do so.

Foot Pursuit Restrictions (630.15)

a. … Sworn member should not engage in or continue foot pursuits in the following circumstances:

1. Armed suspects unless, in extreme circumstances, no other alternative strategy is feasible and a delay in the apprehension of the suspect would present a threat of death or serious physical injury to others.

The Training Division Review and the Commander's Memorandum both addressed the foot pursuit, but focused more on the decision to pursue than on the inherent risk factors and the officer's responsibilities during the pursuit. Both documents ignore or mischaracterize some facts in order to minimize those risks. For example, the Training analysis states that Ajir knew the West Linn officer was "close behind him" and the Commander's Memorandum states Ajir knew his cover officers were "on his heels." In fact, the West Linn officer was 60 to 70 feet away at the time, and the deputy was at least 150 feet away, with only a partial view of the subject. Neither was in a position to help Officer Ajir in immediately defending against Mr. Johnson's aggression.

Both documents also say that Officer Ajir "maintain[ed] distance or "kept a buffer" between himself and the subject. While Officer Ajir stated in his interview and grand jury testimony that he was intending to keep his distance, the

reality was that he had closed the distance enough so that when Mr. Johnson turned to come back towards him, they were only seven or eight feet apart. The TriMet video supports this statement. The fact that the subject was able to turn and advance so quickly that Officer Ajir was immediately in fear for his life suggests there was not an effective buffer between the two as the officer pursued.

Nor did the reviewing documents discuss the lack of any meaningful communication about the foot pursuit. Officer Ajir broadcast that he was in pursuit but did not give his location or direction of travel. Rather, he said since he was in the lead, he counted on the other two involved officers to handle the broadcasts. Neither of them did. Regardless, PPB policy is clear that the pursuing sworn member has a responsibility to notify the Bureau of Emergency Communications and provide specific information about the subject and the pursuit. Neither the West Linn officer nor the Clackamas deputy share this same responsibility, as each is trained in and held accountable to the requirements of his agency's policies, not PPB directives.

We addressed concerns about the multi-jurisdictional nature of Transit as early as 2010, when we issued a report on the death of James Chasse. In that report, we noted that because Transit officers are all trained differently and work under divergent policy expectations, there is a potential that those officers will react differently in dynamic situations. We recommended then and reiterate now that The Bureau should work with other agencies to develop a core set of policies and key tactical training doctrines to promote consistency in the responses of various protected entities.

> RECOMMENDATION 27: The Bureau should identify key operational and tactical policies and training doctrines and develop a focused training program to provide all Transit officers an understanding of these core concepts.

Finally, both the Training Division Review and Commander's Memorandum discuss the significance of the fact that Mr. Johnson was pumping his arms and looking straight ahead, not reaching for his pocket or waistband or turning around to see the officer's position. The former is consistent with a subject who simply wants to get away, while the latter movements may be indicative of an intent to acquire a weapon and attack the officer. However, neither discussed the significance of the fact that Officer Ajir believed that the subject had some sort of weapon based on the original call information. PPB policy generally prohibits foot pursuits of armed subjects except in "extreme circumstances" that do not seem to have been present here.

Consistent with the findings of Training and the Commander that Officer Ajir's actions were consistent with training and complied with the Foot Pursuit Directive, the Police Review Board did not have any substantive discussion of the issues surrounding this foot pursuit and made no contrary determination.

Here, for formal findings of the Police Review Board, the Foot Pursuit Directive was grouped into an "Area of Review" that included the Application of Deadly Force, creating the implication that if the foot pursuit is found out of policy, then the deadly force may likewise be out of policy. While it may be true that a tactically unwise foot pursuit may lead to a use of force that was not, in the strictest sense, necessary or unavoidable, an out-of-policy pursuit does not necessarily mean the force was out of policy. Tying the two findings together may lead to a less-than-rigorous review of the foot pursuit in an effort to avoid a conclusion that the force was out of policy. In deadly force cases involving a foot pursuit, the pursuit should be reviewed independently.

> RECOMMENDATION 28: In officer-involved shootings and other critical incidents involving a foot pursuit, Internal Affairs, Commanders, and the Police Review Board should consider whether officers' actions complied with the Foot Pursuit Directive as an Area of Review separate from the review of the application of deadly force.

Communications Issues

Information about Possible Weapons

The initial 911 caller indicated that she did not see a weapon on the subject. The West Linn officer knew before Officer Ajir and his brother arrived on scene that the subject had a knife in his pocket but did not communicate that information before Mr. Johnson ran and the officers pursued. The initial call voiced to Officer Ajir made no mention of any weapons, but when he read the call on the in-car computer, it said "now weaps." Officer Ajir believed this was vague and ambiguous but said he did not have time to request further information about weapons during the short drive to the location of the call. Nonetheless, he interpreted the information to mean that the subject had a weapon.

The Training Division Review critiqued the officer's assessment and suggested he should have contacted dispatch to clarify why the call listed "now weaps." Though the Training analysis concluded this was not the most effective tactic, the

Commander's Memorandum neglected to discuss this issue. There was no formal finding on this matter from the Police Review Board.

Dispatching Transit Division Officers

There is no single dispatch system for Transit Division officers. The Division is divided into districts, and officers are responsible for calls relating to the rail and bus lines in all areas serviced by TriMet within each district, throughout Portland and the surrounding cities and county areas. An officer in Transit South, for example, will respond to calls from dispatchers in Portland, Milwaukie, Clackamas County, and Oregon City, among others. All of these dispatch systems operate independently of each other, so that a Portland dispatcher does not necessarily know when a Transit officer handling a call in Clackamas will be available for a new call.

Calls to Transit officers are dispatched via text message to a Bureau-issued cell phone. The text provides a brief summary of the call and the jurisdiction in which it originated. If available, a Transit officer will respond and notify dispatch to assign the call to him or her. The officers then switch to the radio net for that jurisdiction to get further details and updates on the call. Within the City of Portland or Gresham, officers can get information on a call via their in-car computer system. In all other cities and county areas serviced by TriMet, officers must use the radio to voice in their responses because they do not share the same Computer Assisted Dispatch system.

There are significant technological challenges in managing a dispatch system over an area as large as that covered by Transit Division, involving officers from many different jurisdictions. There may be no better solution than the current use of cell phones to alert officers to Transit-related calls. However, the lack of uniformity in how calls are dispatched and how individual officers respond can and does create difficulties.

For example, here Officer Ajir and his partner did not know the West Linn officer had assigned himself to the call, and had no idea he had arrived and was talking to the subject. The West Linn officer knew that the other officers were on the way but did not communicate with them regarding his status. The West Linn officer involved in this incident is not subject to formal review by the Bureau administrative investigation, and the Training analysis did not evaluate this communications issue. Despite the Bureau's lack of formal authority over this officer, though, the issue could have and should have been flagged as a subject for debriefing of this officer and training for all Transit Division officers.

RECOMMENDATION 29: The Bureau should ensure that all Transit Division officers, regardless of which agency they work for, are included in debriefings to address any potential performance issues and are adequately trained in the importance of effective communications.

RECOMMENDATION 30: The Training Division should formally consider and critique the tactical decision making of all officers involved in a joint operation with Bureau officers, regardless of which agency they work for, so that these issues can be included in post-incident debriefings.

Family Members Working as Partners

Officer Ajir regularly works in a two-person car partnered with his brother, a Clackamas County deputy. This is by choice and by design, as the brothers each sought assignments in Transit Division so they could work together. While there is nothing about the conduct of either brother in this case to suggest a problem with this arrangement, there are significant potential disadvantages to having family members work together in such close circumstances. Close family relationships (including spouses, parents, children, or siblings) can create conflicting loyalties and may impact officers' ability to function independent of their unique emotional ties. In addition, their testimony also may be vulnerable to attempts at impeachment based on an inference of bias due to familial ties. For these reasons, many agencies restrict the ability of family members to work on the same assignment. The Bureau currently has no such directive, either for its own officers or for those working assignments (such as Transit) where they regularly partner with officers from outside agencies.

RECOMMENDATION 31: The Bureau should prohibit the assignment of close family members to the same patrol team or specialized assignment.

Timing of Interviews

Officer Ajir declined to provide a voluntary statement to Detectives after the shooting. Following advice from the Multnomah County District Attorney, Internal Affairs investigators did not interview Officer Ajir until June 23 – following the conclusion of grand jury proceedings and nearly a month and a half

after the incident. The officer had testified to the grand jury the day before his interview, but had otherwise not provided a substantive statement about his role in the incident, his observations, or his state of mind, meaning that the Bureau waited 44 days to hear from the only living witness to the event his rationale for decisions he made prior to the use of deadly force and the decision to fire his weapon.

The District Attorney took the position that compelling officers to provide statements in an administrative interview would immunize those officers against criminal liability, effectively preventing an officer from being prosecuted for his or her role in an officer-involved shooting. The Director of the Independent Police Review challenged this legal conclusion, and the City ultimately pressed ahead with its decision to require officers to submit to administrative interviews shortly after an incident. As frequent advocates of the elimination of what was referred to as the "48-hour rule," we welcome this change and look forward to reviewing more timely interviews in future investigations.

SECTION TWO

Common Themes and Issues

Police Review Board Issues

Formal Review of Tactical Decision Making

In our Fifth Report, we recommended that the Bureau modify its protocols so that the review of every officer-involved shooting includes an explicit review of pre-shooting tactical decision making, and express findings from the Commander and Police Review Board on whether officers' tactical performance was consistent with training and policy. We noted that this change could be made consistent with the way the Bureau has added review of "Operational Planning and Supervision" and "Post Shooting Procedures" to its formal review mechanism. While we appreciate that the Bureau has recognized the need to assess tactics leading up to a deadly force incident longer than many other agencies, and specifically tasks the Training Division to identify and address any lapses in tactical decision making, the reviewing commanders and the Police Review Board should focus more consistently on these issues.

For example, in cases reviewed for this report, we found concerns about the way the review process handled issues surrounding a foot pursuit (Terrell Johnson); officers' decision to separate and leave one officer alone with a subject (Ellis and Terrell Johnson); concerns about cover and concealment (Hayes, Liffel, and Bucher); the ways in which officers could have better controlled the pace of an

incident (Hayes and Perkins) and more clearly communicated with a subject (Hayes).

We have repeatedly discussed the ways in which tactical decisions that keep officers safe also reduce the likelihood that officers will find themselves in a position where they feel the need to use deadly force. We know that the Bureau embraces this principle through its training, planning, and expectations for officer performance, but its review process does not always reflect this emphasis. We therefore reiterate the recommendation we made in our last report – that the Bureau should add a separate area of review for pre-shooting tactical decision making to its administrative investigations of officer-involved shootings and require both the reviewing Commander and the Police Review Board to make a finding on the appropriateness of tactics leading up to every incident.[31]

> RECOMMENDATION 32*:* The Bureau should ensure that the administrative investigation of every officer-involved shooting includes an explicit review of pre-shooting tactical decision making and require express findings from the Commander and Police Review Board on whether officers' tactical performance was consistent with training and policy.

Similarly, when the training Division identifies officers' actions as being anything other than "sound and effective,"[32] the Review Board has not always addressed these potential concerns. For example, following the shooting of Mr. Davis, the Training analysis identified two tactics or methods that were not "most effective," but there was no documentation to suggest that the Police Review Board considered these or developed any plan to address the tactical performance issue. To be most effective, the Board should formally discuss each of these training concerns.

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[31] We acknowledge that all of the incidents discussed in this report pre-date the release of our last report but note that in the one Police Review Board hearing we attended (covering an incident that occurred since the time of our last report), tactical decision making was not a formal part of the analysis.

[32] Training employs a four-part rating scale in which officers' actions are deemed to be: (1) "not consistent with training or create an unnecessary or serious risk;" (2) "generally acceptable but create identifiable risks;" (3) "consistent with training, but are not the most effective method or tactic;" or (4) "demonstrate sound and effective tactics."

RECOMMENDATION 33: The Police Review Board should expressly consider all actions rated by the Training Division to be anything other than "sound and effective" and should develop an action plan to address these issues.

Consideration of Systemic Recommendations

We have noted throughout this report valuable recommendations made by Training or a reviewing Commander that did not find their way into any formal findings by the Police Review Board or, ultimately, the Chief.

For example:

- In its review of the incident involving Mr. Davis, Training expressed concerns about training gaps raised by that incident and made several recommendations emphasizing scenario-based training and modifying the content of firearms and defensive tactics training.

- Following the shooting of Mr. Ellis, the reviewing Commander recommended that Training develop a lesson plan based on this incident to discuss control tactics and contact and cover techniques. The Commander also recommended that Training regularly include defensive tactics and ground fighting skills during annual in-service training.

- Following the shooting of Michael Johnson, the Training Division recommended that the Bureau provide supervisory training to all officers on sergeants' promotional lists, consider reviewing the SERT directive on mandatory activation, and issue training updates on the use of ballistic helmets.

RECOMMENDATION 34: The Bureau should develop protocols to ensure that any recommendations made by the Training Division or the reviewing Commander are considered by both the Police Review Board and the Chief.

RECOMMENDATION 35: The Chief should formally accept or reject any systemic recommendations made by the Police Review Board, and for those recommendations accepted, should direct a plan to ensure they are fully implemented in a timely way.

Training for Police Review Board Members

A critical aspect of Portland's officer-involved shooting review process is the role to be played by the Police Review Board. In that forum, members of the Board who have had an opportunity to review the investigative file and the Bureau's initial analysis are able to meet and discuss issues arising from the incident. The Board is entrusted with making recommendations about whether the use of deadly force was within policy and the propriety of post-incident conduct, including the provision of medical attention to injured subjects. We recommend above (and in prior reports) that the Police Review Board should make determinations regarding the propriety of tactical decision making leading up to the use of deadly force and formally consider any individual or systemic recommendations advanced by either the Training Division or the Commander.

What makes Portland's Review Board relatively unique among internal review mechanisms of police agencies is that it includes members of the public. Because we have recommended an increased role for the Review Board in the way it holistically considers incidents, it is important for the City to consider ways to ensure that Board members (particularly the civilian members) are prepared for this role.

The Bureau and the Independent Police Review division facilitate fairly extensive training for community member volunteers who serve on the Citizen Review Committee and the Police Review Board. The 40-hour training (only some of which is relevant specifically to Police Review Board issues) covers topics such as types of force, the use of force policy, the action-reaction principle, how to prepare for a Review Board hearing, and includes some scenario-based training.

This training is essential but may not be sufficient. Because police practices have become increasingly complex, and the skills needed to read a police investigative file and identify issues with the investigation and performance of involved officers are relatively esoteric, we think it is critical for the community member volunteers to be trained in these tasks. In addition, it would be helpful periodically (at least annually) to have all Review Board members involved in joint training to work on strategies so that the expertise and experience of Bureau members and the important outside perspective of civilian members are combined in a productive and healthy discussion of the issues arising from these incidents.

This additional training that we envision for the Review Board should not be a Bureau training initiative. It should be independently facilitated and involve a

session with only civilian members of the Board that focused on issue spotting and general police practices followed by a session with the entire Board. The training should be scenario-based and independently facilitated.

> RECOMMENDATION 36: The City should develop additional training components for its Police Review Board to ensure members are sufficiently prepared for the task of identifying investigative and performance issues associated with their review of critical incidents.

Tactical Retreat

In three of the nine cases we reviewed in this report – Davis, Ellis, and Terrell Johnson – officers fell while backing away from individuals who were advancing on them with potentially deadly weapons. In all three cases, the stumble or fall while backpedaling put the officers in a position of disadvantage as the subjects continued to advance. In the Davis case, the tactical disadvantage the officer found himself in after he stumbled likely contributed to his decision to use deadly force. In Ellis, the fall caused the partner officer to break his wrist, allowed the subject to stab the officer, and made further retreat impossible. And in the incident involving Terrell Johnson, the officer tripped over a curb and fell backward, then fired his weapon from his position on the ground because he was unable to further retreat from the subject, who continued to move toward him with a knife.

In its review of the Ellis shooting, the Training Division recommended reinforcement through training of the tactic of moving "off line" rather than backpedaling when attempting to avoid a sudden attack. The "off line" technique is a sideways move that avoids the direct line of attack and reduces the likelihood of the officer stumbling or falling. Some trainers also teach a side step approach that increases distance, allows the officer to maintain visual contact with the individual as well as assess his or her direction of travel, while also remaining more surefooted. The reviewing commander in Ellis concurred with Training's recommendation and emphasized that the Training Division should discourage backpedaling and teach dynamic lateral movement techniques in its course of instruction on tactical defensive maneuvers.

It is unclear whether Training followed up on its own recommendation, but there is no record of it being addressed, let alone formally adopted, by the Police

Review Board or advanced to the Chief. To the extent it has not incorporated an emphasis on alternative techniques for backing away from an armed, advancing subject in its tactical maneuvers classes, Training should adjust its curriculum to adopt its own 2015 recommendation.

> RECOMMENDATION 37: The Training Division should examine and adjust its curriculum on tactical defensive maneuvers to include an emphasis on lateral movement techniques that allow officers to move away from armed, advancing subjects while minimizing the chance of stumbling or falling.

Further, it is notable that the Training analysis of the Terrell Johnson incident did not include any reference to specific training on defensive maneuvering techniques that could minimize the risk of falling, despite the fact that the shooting officer was put at such a tactical disadvantage as a result of tripping while backpedaling, and the fact that this had been an issue identified by the Training Bureau in two other relatively recent incidents. The Johnson shooting occurred nearly two years after the Ellis incident and three years after Davis. While the circumstances in each were somewhat different, the basic scenario in each shared similarities that should draw the attention of Bureau managers and trainers. Informally, there is some indication that the Training Division does take note of such similar fact patterns and includes lessons learned as it develops new training scenarios and curricula for in-service training. Recent changes to Training Division practices will result in this effort becoming more formalized.

A critical incident shines a spotlight on Bureau practices and procedures and provides an opportunity to examine training and performance issues in a meaningful way. Proactive supervisors and executives can and should look beyond the facts of a single incident and think more broadly about other recent incidents to identify patterns and craft possible solutions. Many incidents – critical and non-critical – within the experience or knowledge of supervisors and executives may involve tactical problems or officer safety issues relevant to such patterns. The Bureau should seek ways to encourage and incentivize its members to take initiative and consider critical incidents in this way.

> RECOMMENDATION 38: The Bureau should encourage its managers and trainers to examine critical incidents more broadly, looking beyond a single incident to identify similarities and patterns among all recent incidents.

Officers Involved in Multiple Shootings

Two of the officers involved as shooters in cases we review in this report – Officers Corno and Hearst – have been involved as shooters in cases we reviewed in prior reports. We have twice previously addressed a similar issue in our Third and Fourth Reports (November 2014 and January 2016). Indeed, Officer Corno's prior two shootings were the specific subject of discussion in our Third Report.

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

> *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.*

The fact that an officer has engaged in multiple shootings does not necessarily point to a problem or concern, but given the high stakes involved in a use of deadly force, it is a fact that should be considered and evaluated as part of a thorough review. Therefore, we reiterate verbatim the recommendations we made in our January 2016 report (where they were numbered Recommendations 29 and 30):

> RECOMMENDATION 39: 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 40: 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.

In its response to our 2014 report, the Bureau indicated that because the Review Board's primary purpose is to provide a recommendation to the Chief whether or not the member's use of force was within policies, it would not be appropriate to discuss prior shootings until the Board evaluated the present case on its own merits. An officer's prior shooting history would only be provided if the Board reaches a finding that an officer's conduct was out of policy.

Interestingly, the investigative file provided to the Review Board routinely contains the entire criminal history of any individual shot by an officer, without concern for its potential relevance. More significantly, and consistent with our themes in recent reports, the Review Board should be more expansively considering the entire incident, rather than merely whether an officer's actions were within policy. And as the Bureau itself has recognized, a finding that an officer's use of deadly force is in policy does not preclude debriefing or other remedial measures intended to address tactical decision making or other performance. While not presumptive, a careful analysis of the instant shooting in light of the prior shooting(s), might identify a pattern of conduct that justifies more tailored training or even reassignment of the officer.

It is fact that most police officers never use deadly force in their careers and only the smallest percentage of officers are involved in multiple shootings. To keep any prior history from the Review Board necessarily precludes further discussion of remediation where the shooting is found to be in policy. As a result, the Review Board is incapable of considering any possible pattern of performance issues presented when an officer has two, three or even more prior shootings. We reiterate the Recommendations made four years ago and urge the Bureau to reconsider their position.

Timeliness of Investigations

The settlement agreement between the City of Portland and the Department of Justice was finalized and accepted by the federal judge in August 2014. The settlement agreement established, among other things, a 180-day time limit for the Bureau to complete all internal investigations and review processes following an officer-involved shooting. The Bureau complied with this deadline in all but two of the nine incidents we review in this report (and one of those was overdue by just eight days). The table below includes two additional cases commenced after the implementation of the settlement agreement (discussed in our previous report) and shows that investigators completed 11 out of 13 within the 180-day time limit.

In the one significantly overdue case covered in this report – the incident involving Terrell Johnson on May 10, 2017 – a number of factors were at play. The Detectives' investigation took six weeks longer than its allotted time, largely because of the coordination with TriMet over a sizeable number of videos from various trains and platforms that had to be gathered, copied, and reviewed. This likewise set the Internal Affairs investigation and Training Division Review back a bit, as did complications over the timing of the interview of the involved officer as a result of the District Attorney's intervention (as covered in our individual discussion of the Terrell Johnson case, above). Finally, the case was delayed in getting to the Police Review Board, presumably because of the Thanksgiving holiday. These factors were principally outside of the Bureau's control, and the fact that the remaining eight cases were completed within the 180-day timeframe demonstrates that this case was an anomaly and not a cause for great concern.[33]

The following table depicts all of the incidents that have occurred since the Bureau's agreement with the DOJ to complete its investigation and review process within 180 days, plus the incident involving Mr. Davis, which occurred just prior to finalization of the agreement. The shaded rows are the officer-involved shootings covered in this report.

[33] However, as discussed in detail in Healy, a potential greater cause for concern is the decision not to interview identified witnesses so that the case can be timely completed. Even though in Healy the Bureau had an additional fifty days under the DOJ agreement to complete the investigation, it chose not to interview witnesses who had been identified as having potential evidentiary value. The thoroughness of investigations cannot be sacrificed to meet an internal deadline.

Timing to Completion of Investigation and Review

Subject's Name	Date of Incident	Time to Case Closure
Terrell Johnson	5/10/2017	224 days
Don Perkins	2/9/2017	138 days
Quanice Hayes	2/9/2017	144 days
Steven Liffel	12/5/2016	172 days
Timothy Bucher	5/24/2016	150 days
Michael Johnson	11/6/2015	160 days
David Ellis	7/5/2015	141 days
Alan Bellew	6/28/2015	143 days*
Michael Harrison	5/17/2015	116 days*
Christopher Healy	3/22/2015	140 days
Ryan Sudlow	2/17/2015	321 days*
Denoris McClendon	9/1/2014	163 days*
Nicholas Davis	6/12/2014	188 days

* These times are calculated based on the date of Review Board hearing, per our practice in prior reports. Because the DOJ deadlines are based on the date the case was formally closed, the newer cases use this date, which includes time for the Review Board's recommendations to be sent to and considered by the Chief, after which the administrative case can be "closed" via official notice to the reviewed members.

SECTION THREE Recommendations

1 When a legal issue arises regarding the Fourth Amendment, the Training Division should consult with an attorney with a legal background in Constitutional jurisprudence.

2 In evaluating post-shooting performance, the Training Division Review should evaluate whether there were alternative strategies that on-scene officers could have used to render medical aid more quickly.

3 The Bureau should not place detailed criminal histories at the beginning of its detective file, to emphasize that the facts of the incident are the appropriate and primary focus of the investigation.

4 The Bureau should prepare and include in the investigative file a time line setting out relevant events from the initiation of the call for service or initial police contact to the time paramedics initiate evaluation of the person shot.

5 The Bureau should devise directives requiring officers to accurately communicate when they are on-scene at a dispatched call.

6 When an officer-involved shooting reveals statements by officers referencing a disregarded tactical principle such as the 21-foot rule, the Bureau should debrief the officer regarding its preferable tactical philosophy.

7 The Training Division should continue to instruct Bureau supervisors on the directives required during the management of a critical incident.

8 The Bureau should use IPR's subpoena authority when necessary to achieve cooperation from witnesses.

9 Internal Affairs should ensure that all reasonable efforts are made to interview identified witnesses even if doing so might impact the deadline for completion of the investigation.

10 In officer-involved shooting investigations, the Bureau should video record interviews of involved and witness officers.

11 When a witness objects to the recording of an interview or recording the interview proves impracticable, the investigative reports should provide an explanation.

12 The Training Division Review, Commander's Memorandum, and internal review process should identify any tactical decision making that results in partners being separated and required to detain subjects alone.

13 The Bureau should adopt a policy or protocol prohibiting a member who was even minimally involved in a critical incident from being part of the investigative team.

14 The Training Division should prepare briefings and/or a Training Bulletin to remind officers and supervisors about the usefulness of ballistic helmets in tactical incidents and should include this information in the curriculum for its critical incident training.

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

16 The Bureau should reinstate its prior "cover fire" policy expressly in the Directives including the "use with extreme caution" language.

17 The Bureau should ensure that its training message and any written protocols concerning the capabilities of its armored vehicles to provide cover against a variety of weapons is clear, consistent and fact-based.

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

19 Whenever a supervisor becomes tactically involved in a deadly force situation, the Commander's Memorandum, the Training Analysis, and the Review Board should all opine on whether such involvement was consistent with Bureau directives.

20 The Bureau should continue to use surveillance footage of Bureau operations for training purposes but should develop handling procedures for recently recorded videos that ensure investigators have interviewed Bureau witnesses about the incident before videos are shown.

21 The Bureau should evaluate the practicality of streamlining and standardizing the incident commander's decision factors for activating SERT.

22 All of the Bureau's reviewers – Training, Commander, and Police Review Board – should consider all contributing causes in their analysis of a delay in providing medical care.

23 The Training Division, Internal Affairs, and Commanders should identify, analyze and assess all of the tactical considerations surrounding a given incident, including the effectiveness of particular commands and warnings officers gave to the subject.

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

25 The Bureau's Training Division should eliminate the phrase "left the officers with no other option…" from their analyses.

26 The Police Bureau should work with the City to evaluate the practicality of procedures that would require the Bureau of Emergency Communications to initiate locating technology early in the dispatch/assignment process so that officers can expend less time searching for 911 callers who raise a credible threat of suicide or other source of imminent death or injury.

27 The Bureau should identify key operational and tactical policies and training doctrines and develop a focused training program to provide all Transit officers an understanding of these core concepts.

28 In officer-involved shootings and other critical incidents involving a foot pursuit, Internal Affairs, Commanders, and the Police Review Board should consider whether officers' actions complied with the Foot Pursuit Directive as an Area of Review separate from the review of the application of deadly force.

29 The Bureau should ensure that all Transit Division officers, regardless of which agency they work for, are included in debriefings to address any potential performance issues and are adequately trained in the importance of effective communications.

30 The Training Division should formally consider and critique the tactical decision making of all officers involved in a joint operation with Bureau officers, regardless of which agency they work for, so that these issues can be included in post-incident debriefings.

31 The Bureau should prohibit the assignment of close family members to the same patrol team or specialized assignment.

32 The Bureau should ensure that the administrative investigation of every officer-involved shooting includes an explicit review of pre-shooting tactical decision making and require express findings from the Commander and Police Review Board on whether officers' tactical performance was consistent with training and policy.

33 The Police Review Board should expressly consider all actions rated by the Training Division to be anything other than "sound and effective" and should develop an action plan to address these issues.

34 The Bureau should develop protocols to ensure that any recommendations made by the Training Division or the reviewing Commander are considered by both the Police Review Board and the Chief.

35 The Chief should formally accept or reject any systemic recommendations made by the Police Review Board, and for those recommendations accepted, should direct a plan to ensure they are fully implemented in a timely way.

36 The City should develop additional training components for its Police Review Board to ensure members are sufficiently prepared for the task of identifying investigative and performance issues associated with their review of critical incidents.

37 The Training Division should examine and adjust its curriculum on tactical defensive maneuvers to include an emphasis on lateral movement techniques that allow officers to move away from armed, advancing subjects while minimizing the chance of stumbling or falling.

38 The Bureau should encourage its managers and trainers to examine critical incidents more broadly, looking beyond a single incident to identify similarities and patterns among all recent incidents.

39 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.

40 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.

Appendix

Table of Critical Incidents Reviewed by OIR Group

2004 – 2017

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

Table of Critical Incidents Reviewed by OIR Group

2004 – 2017

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

Table of Critical Incidents Reviewed by OIR Group

2004 – 2017

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

Table of Critical Incidents Reviewed by OIR Group

2004 – 2017

Subject's name	Date	# of involved/ shooting officers	# of rounds fired	Officers' weapon(s)	Hit/ non-hit	Fatal/ non-fatal	Subject weapon?	Subject's Race	Mental health issues	Officer(s) disciplined?
Timothy Bucher	5/24/16	2	16	M4 rifle; .223 rifle	Non-hit	Non-fatal	Assault rifle and handgun	White	Yes	No
Steven Liffel	12/5/16	1	1	AR-15	Hit	Fatal	Rifle and handgun	White	Yes	No
Quanice Hayes	2/9/17	1	3	AR-15	Hit	Fatal	Replica handgun	African-American	No	No
Don Perkins	2/9/17	2	10	AR-15; 9mm	Hit	Non-fatal	Replica handgun	White	Yes	No
Terrell Johnson	5/10/17	1	4	9mm	Hit	Fatal	Knife	African-American	No	No

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

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