City of Portland

Portland Police Bureau Officer-Involved Shootings and Critical Incidents

Eighth Report
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OIR GROUP

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Introduction

This is our eighth report on Portland Police Bureau ("PPB" or "Bureau") uses of deadly force and in-custody deaths. The landscape has changed significantly since we published our last report on officer-involved shootings, in April 2020, at the very beginning of the global COVID-19 pandemic and just before the murder of George Floyd set off a wave of protests across the country that focused an unprecedented level of attention on law enforcement and its fraught relationship communities of color. In Portland, the demonstrations for racial justice were unparalleled in their duration and intensity, but also for the degree to which they sparked counter-protests and violent clashes between ideological opposites. The extent to which events in Portland became a national story and a symbol of a broader political divide has underscored the Bureau's work over the past years.

Since our last officer-involved shooting report, the Bureau has also sworn in another new Chief (seven in the 12 years since we first began our work with the City, and four in the last five years) and faced new hurdles in its effort to comply with the terms of a 2014 settlement agreement with the U.S. Department of Justice (USDOJ). That agreement stemmed from a finding that the Bureau had a pattern of using excessive force on individuals experiencing mental illness. At the time of our last report (over two years ago), the City was thought to be in substantial compliance with the terms of the agreement, which required the Bureau to make changes to the way it addressed mental health concerns but also resulted in significant adjustments to the Bureau's investigative protocols and internal review processes. Since then, however, the City has regressed in the USDOJ's assessment, based on questions relating to the thousands of force deployments during the 2020 protests and gaps in its record-keeping, review, and accountability measures.

This larger picture provides an important backdrop to this report. But because of the lag between when officer-involved shootings happen and when we report on them, the incidents we review here all took place in

2018 and 2019, before most of the world knew the term “coronavirus” and George Floyd’s murder had galvanized new demands for police reform.

We address eight incidents in this report – seven officer-involved shootings and one use of a choke hold (categorized as deadly force but that did not result in death). As with our prior reports, our review looks holistically at each of these critical incidents, to assess the degree to which the Bureau’s investigative and review process addressed tactical decision-making, efforts to de-escalate and to make use of all available tools and equipment, and the effectiveness of supervisors to manage and direct resources and control the scene.

Among the eight incidents we review here, we noted the frequency with which Bureau members acted to protect uninvolved third parties. In two cases – involving David Downs and Jeb Brock – officers shot the subjects while they attempted to use victims as shields. In three others – involving Andre Gladen, Samuel Rice, and Ryan Beisley, officers took positions and moved more quickly than they might have otherwise because of a perceived risk to others.

Another shared fact among many of these cases – a commonality that is all too consistent across our years of work in Portland – is the mental health concerns surrounding the involved subjects. Of the eight cases we review here, at least four involved subjects who had some history of mental health issues or were experiencing some type of mental health and/or addiction crisis. This is not always easy to determine with precision because of the definitional problem of what it means to be “in mental health crisis.” This is particularly true when the encounter with police is fatal and there is no opportunity after the shooting to hear the subject’s perspective or understand his motivations. But the influence of mental health concerns on several of these incidents seems unmistakable.

The Bureau’s approach to behavioral health issues has evolved significantly since our first project with the City in 2010 – reviewing the Bureau’s response to the 2006 death of James Chasse. Crisis Intervention Team training became a priority after that incident, and then the 2014 USDOJ settlement agreement prompted allocation of substantial resources aimed at improving outcomes for those in crisis. The Behavioral Health Unit and the Enhanced Crisis Intervention Team are two innovations aimed at better coordinating effective responses to those in crisis. And all of the Bureau’s training associated with crisis response

emphasizes exercising patience, marshaling resources, and considering disengagement when there is no threat to others.

We saw this training at work in many of our cases. For example, in Mr. Gladen's case, an earlier encounter with police on the day of the fatal shooting had ended when responding officers called paramedics to address his obvious medical and mental health needs rather than take him into custody. And in the case involving Mr. Rice, officers had disengaged from an encounter with him several days before when they determined he no longer posed a threat.

Yet recognizing – and safely accommodating – a subject's compromised decision-making can be challenging in a moment of conflict. And while Bureau officers are trained to consider potential indicators of a mental health crisis to inform their approach, the need to protect others and themselves from immediate danger must sometimes take priority. For example, to the officers who confronted Mr. Brock in the midst of his assault on a female victim, his mental health status was subordinate to their exigent need to free the victim from his grasp. Nonetheless, the responding sergeant brought his crisis-related training to bear, as he said he consciously tried to lower the tone and intensity of his voice in the hope it would de-escalate the encounter. In other cases, such as the one involving Mr. Rice, the decision by one officer to use deadly force while a team of tactical specialists and command staff on scene were endeavoring to resolve the matter short of deadly force, the officer's threat assessment should have received greater internal scrutiny.

As with prior reports, our evaluation of these incidents is not to second-guess the outcomes, though we do point out where we see officer performance that appears to be inconsistent with Bureau directives and expectations. Instead, we focus on the Bureau's own internal investigations and review processes to evaluate how well they identify and respond to concerns with officer decision-making and, more broadly, systemic issues that may impact future incidents. And as we have noted in recent reports, the review process we examined in these eight incidents continued to miss some marks in addressing important tactical issues.

Memoranda from the Commanders tasked with evaluating investigative reports too often are simple boiler-plate adoptions of the Internal Affairs recommended findings, and neither Internal Affairs, the Commander, nor the Police Review Board regularly delve into tactical issues that lead up to

uses of deadly force. While we noted some important issues not addressed by the Training Division, more often Training produces thorough, insightful analyses that are unfortunately ignored by other participants in the Bureau's multi-layer review process.

Adding the eight cases we review in this report to our prior work, we have examined a total of 65 critical incidents involving the Police Bureau over the past 12 years.[1] We have made numerous recommendations on a range of issues – some relating broadly to the Bureau's internal review processes and others relating more specifically to the circumstances presented in individual cases that suggest the need for shifts in training, policy, or operations. We have historically had constructive dialogue with the Bureau's leadership as we frame these recommendations with the shared goal of learning and improvement. In the end, Bureau leadership has indicated they agree with nearly all the recommendations we've made over the years. And in the earlier years, we have seen some particularly notable improvements – for example, in the speed with which Bureau members approach and provide medical aid to injured subjects. Unfortunately, though, leadership's agreement with our recommendations has not regularly translated into implementation, and we often repeat ourselves from one report to the next. Part of this can be attributed to the frequent leadership change at the Chief position, with earlier commitments not followed through by a successor administration.

One thing that has not changed over our decade-plus engagement with the City is the unavailability of body-worn camera footage of these incidents. Officers are equipped with cameras in every other jurisdiction in

[1] With this report, we have examined all officer-involved shootings and in-custody deaths for which the investigation and administrative review was complete by January 1, 2021. As we have done for each of our prior reports, we reviewed all of the Bureau's investigative materials for each of the seven critical incidents we evaluate here, including the Detectives' and Internal Affairs' investigations, as well as grand jury transcripts where available. We also read and considered the Training Division Review and materials documenting the Bureau's internal review and decision-making process connected with each incident. We requested, received, and reviewed relevant training materials, referred back to training materials we reviewed for our prior reports, and spoke with current Training Division personnel. We talked with Bureau executives regarding questions that were not answered in the initial materials provided and requested additional documents that were responsive to those questions.

which we work, and our review of officer-involved shootings (or any uses of force) benefits from our ability to see and hear what happened before, during, and after the incident. Cameras are not perfect – the angles and lighting can be bad, and they only provide one perspective and sometimes miss elements of an encounter. But they provide a much more complete picture than simply relying on officer and witness statements to understand the dynamic in each incident. Viewing body-worn camera footage has become such an integral part of our work with other agencies that it now feels like our review is incomplete if we have not seen the event unfold on our computer screens. We understand the Bureau may soon be deploying body-worn cameras, and we applaud that development.

Officer-Involved Shootings and Uses of Deadly Force

August 31, 2018 ◦ Jonathan Harris

A woman called the PPB to offer a tip about her ex-boyfriend, who had just made an unwanted visit to her home. She claimed he had a felony warrant, and this was confirmed by dispatch in assigning the call. Two officers (Timothy Giles and Larry Wingfield) arrived separately at the scene and then approached the subject, Jonathan Harris, who was outside with the woman in a driveway area outside the woman's building. He matched the description of the subject that the officers had been given, and the woman also corroborated this by gesturing as the officers came into view.

The officers and subject spotted each other from approximately 30 yards away. (The officers were in full uniform, and the area was well-lighted.) They had concern from Mr. Harris's facial reaction that the man was thinking about running, and one of the officers attempted to de-escalate through casual conversation as they got close enough to contact him. Once they were within reach, Officer Giles informed Mr. Harris that he had a warrant and was under arrest.

Mr. Harris tensed up in response and each officer grabbed one of his wrists. The officers' attempts to detain him quickly devolved into a physical struggle. As they grappled to get him into handcuffs against his resistance, Officer Wingfield twisted him to the ground. Mr. Harris continued efforts to get away, wrested an arm from one of the officers, and tucked it under his body. Officer Giles got on the radio to call for assistance as they pressed

down on him with body weight and gave repeated orders that Harris was ignoring.[2]

For Officer Wingfield, the strategy became one of attempting to outlast Mr. Harris while waiting for backup. Meanwhile, Officer Giles continued his efforts to pull Harris's arm out from under him. Wingfield leaned over to assess what was happening; it was at that point that he noticed what he believed was the butt of a gun. He focused on Harris's movements in a new way, and within seconds Harris's arm emerged from underneath him. The gun was in his left hand, in a direction pointed toward Officer Giles. Wingfield reached toward the gun and grabbed the muzzle in an effort to pin it down and away from his partner, and Mr. Harris pulled it back under his own body.

This phase of the struggle continued, with Mr. Harris not complying with multiple commands to drop the weapon. According to Wingfield's account to Internal Affairs, he believed he was in a deadly force situation in light of the threat to his partner. However, he was also concerned (albeit mistakenly) that the gun possessed by Harris had been taken from his own holster during the course of the grappling on the ground. Among other things, this deterred him from letting go to reach for his own weapon. He decided to use his left hand and arm to try controlling Harris's movements with the gun, and used his right arm to reach for Harris's head and neck.

His stated intent in this maneuver was to restrict Mr. Harris's head movement and then to press down on one side of his neck in order to impede his breathing. He held this position with his right arm for what he estimated was 30 to 40 seconds. Meanwhile, Officer Giles delivered punches to Harris's lower back in a further effort to overcome his resistance. Officer Wingfield described Harris as losing vigor (including claiming that he could not breathe), but that the confrontation did not really turn until a third officer arrived. That officer (David Harding) attempted to pull out Harris's arm, and then delivered multiple punches to his back area in an effort to gain compliance.

[2] Officer Wingfield later explained in his administrative interview that part of his motivation in making announcements was to inform bystanders that the man had a warrant, and that there was justification for their attempts to arrest him.

A fourth officer (Huntley Miller) arrived and took hold of one of Mr. Harris's arms. The two later arriving officers were the ones to ultimately secure Harris into handcuffs. The weapon, a Model 19 Glock handgun, was recovered by responding officers. The entire incident had lasted approximately four to five minutes.[3]

Mr. Harris was placed under arrest. Officer Wingfield promptly reported his use of the neck hold to the acting sergeant who responded to the scene. Medical personnel also responded and cleared Mr. Harris (who had not lost consciousness and was not complaining of pain) for booking. Although Mr. Harris professed not to be injured, the Bureau's deadly force review protocol was initiated based on the belief that Officer Wingfield had attempted a carotid control hold in his efforts to control the subject.

Mr. Harris agreed after a Miranda advisement to be interviewed by PPB detectives on the night of the incident. They spoke for approximately 45 minutes. Mr. Harris acknowledged having a weapon for his own protection when he was confronted by the officers – who he said had approached him "hostilely" and immediately grabbed him without notifying him of his rights. He professed to be uncertain about their identity as officers (a point which investigators challenged at some length).

Harris blamed the officers for provoking his subsequent resistance through their aggressive approach and their decision to throw him to the ground. Their ongoing physical force against him made him, if anything, less inclined to be cooperative. In his version of events, he was seeking to "dislodge" the weapon that was in his waistband area (as opposed to arming himself against the officers). He claimed to have ultimately "relinquished" the weapon of his own accord.

Harris asserted that the officers made threatening statements (including that they would "crack my skull") and itemized some of the force that he considered inappropriate, including kneeing him, stepping on his calves, and pressing his face into the ground. Investigators made specific and repeated inquiries about whether he had been subjected to a "choke hold"

[3] This was by the estimation of Officer Wingfield.

or “carotid hold,” but he was dismissive of this. At one point he said they were attempting to choke him, but he had not allowed it to happen.[4]

A range of criminal charges were filed against Mr. Harris.

Approximately one week after the incident, the District Attorney’s Office determined that the case did not meet the criteria for presentation to the Grand Jury, and that it would itself not be conducting a further review. The officers’ actions were reviewed administratively pursuant to the Bureau’s deadly force “Reporting and Investigation Procedures.” The Internal Affairs review found that all of the evaluated officers had been in compliance with applicable PPB policy. This determination was supported by Commander, the Police Review Board, and the Chief. Similarly, the Training Division assessed the incident across several phases, from the officers’ tactics in initially contacting Mr. Harris through their respective uses of force and the Acting Sergeant’s subsequent response to the scene. In each instance, the actions were deemed to have demonstrated “sound and effective tactics.” Training had no recommendations.

Timeline of Investigation and Review

8/31/2018	Date of Incident
2/26/2019	Internal Affairs Investigation completed
3/12/2019	Training Division Review completed
4/4/2019	Commander’s Findings completed
5/15/2019	Police Review Board meeting
5/15/2019	Case Closed

[4] In subsequent media appearances and legal actions, Mr. Harris characterized the incident as having been more threatening.

OIR Group Analysis

The Bureau moved quickly to identify this case as one that implicated its deadly force "Reporting and Investigation Procedures."[5] This was in spite of some ambiguity as to whether Officer Wingfield's actions had constituted a "carotid hold" or was otherwise at a level that definitionally amounted to deadly force at all. Officer Wingfield described what he had done to an acting sergeant at the scene, and the latter believed that there were enough details to warrant the full review protocol. He initiated it at the scene, and the Bureau's response proceeded from there accordingly. The choice to resolve any ambiguity in the direction of a full-fledged review was appropriate, and led to a careful consideration of the event.

Interestingly, until the George Floyd murder, police agencies around the country had been split in their categorization of the carotid hold[6] as deadly force or something lesser. The hold had been championed by advocates as a safe and effective technique that, when properly applied, actually *reduced* the overall likelihood of serious injury to a resistive subject (and therefore should be more freely available to officers as an option). Accordingly, many agencies considered it to be "controlling force" only. But counter-arguments focused on the inherent danger of force applied near the head and neck, and the difficulties in effectively executing the carotid hold in a "textbook" way under volatile conditions in the field. And in fact, improperly applied carotid restraints had resulted in broken tracheas and death to persons upon whom the hold was applied. As a result, there are reasons why the carotid is so frequently blurred in public perception with a "chokehold" that impedes breathing and can easily damage the throat or neck.

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[5] As part of the City's agreement with the United States Department of Justice, the Bureau included the use of a carotid hold as an automatic basis for undertaking its full investigative protocol.

[6] The carotid control hold is a type of "vascular neck restraint" that differs from the respiratory restraints or "chokeholds" that restrict a subject's airflow. To perform a carotid restraint, an officer uses his or her forearm and upper arm to create a V and put pressure on a subject's carotid artery, limiting oxygenated blood flow to the brain and causing brief unconsciousness. When done properly, no pressure is applied to the trachea, so there is no risk of asphyxiation. However, as noted above, both carotid control holds and chokeholds are now prohibited by the State of Oregon except for deadly force situations.

While controversy and divergent approaches relating to the carotid hold existed for some time, concerns about neck restraints have been magnified in recent years in reaction to high profile tragedies, including the deaths of Eric Garner in New York City in 2014 and the murder of George Floyd in Minneapolis.[7] This has led to major shifts in the policy approaches of many agencies throughout the country – including a state-wide ban in California. And following the George Floyd murder, Oregon enacted a state-wide ban on peace officers from using any physical force that impedes the normal breathing or circulation of the blood of another person by applying pressure on the throat or neck of the other person, which would include both "chokeholds" and "vascular neck restraints" except in a deadly force situation.

Portland's experience in this realm actually dates back to 1985, with the death of a Black man named Lloyd Stevenson after the application of a neck restraint by a PPB officer that was – and remains – a source of significant controversy. The Bureau banned the carotid – except in a deadly force scenario – in the aftermath of that case. Accordingly, the use of the technique is extremely limited. For the responding sergeant, the references by Officer Wingfield to an attempt to "choke out" the subject sufficed as a basis for ensuring that proper investigative thoroughness ensued.

With this in mind, the ensuing criminal and administrative investigations into the officers' conduct initially focused on the actions of Officer Wingfield (as well as the actions of the acting sergeant in handling the immediate aftermath). However, several months later, the Bureau decided to expand the formal assessment to include the force used by the three other involved officers.[8]

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[7] To reiterate, the events in this case pre-dated Mr. Floyd's murder in Minneapolis and the subsequent reforms it prompted.

[8] Those three officers were each invited to participate in a second Internal Affairs interview in light of their changed status as focused members in the incident. However, they had discussed their own actions originally, and each declined to elaborate. Additionally (and weeks after the initial closure of the review process), the Bureau tested and ran records on each of the involved officers' Tasers to confirm that none had been used in the incident. It is unclear what prompted this step, although Harris's former girlfriend – who had called the police and who witnessed much of the subsequent encounter – had made a reference to possibly hearing a Taser when she spoke with investigators.

With the exception of Officer Wingfield, who declined to be interviewed by criminal investigators, the other involved officers gave statements to detectives on the night of the incident. Wingfield spoke with Internal Affairs investigators for some two hours on September 2, and the others had administrative interviews at various times in the following few weeks.

For purposes of the deadly force analysis, the key issues were slightly unusual: they involved not only the question of whether deadly force was justified under PPB policy, but also whether Wingfield's unorthodox efforts to restrict the breathing of Harris constituted deadly force at all.

With regard to the question of whether deadly force had been justified, Officer Wingfield took the position that it had been. This was driven entirely by the combination of Mr. Harris's lack of cooperation and his possession of a gun in a hand that officers had not been able to completely control. In his interview with Internal Affairs investigators, Wingfield mentioned his belief that Giles in particular was vulnerable to being shot. He also described covering the muzzle with his fingers at one point, and recognizing that he could possibly be hit himself.

Officer Wingfield came across in his lengthy interview as having made thoughtful assessments throughout the encounter. For example, he stated that part of his orders and directions as he and his partner struggled with Mr. Harris was meant for the benefit of three men who were standing nearby. His goal was to indirectly inform them of what was happening and dissuade the men from having any sort of hostile reaction of their own that might complicate the officers' vulnerable position on the ground. He also said that – in the midst of their physical struggle to overcome Harris's resistance – he attempted to articulate the Miranda rights to defuse Harris's protests that the officers hadn't provided them. (This was confirmed by Officer Giles.)

More specifically, his thought process shaped his decision-making about deadly force in notable ways. He said that he had initially refrained from alerting Giles about the gun because he wasn't sure that what he had seen actually was a weapon, and he did not want to provoke his partner into a shooting that was not necessary.

Additionally, he said that he chose not to go for his own weapon because of the possibility that the gun Mr. Harris possessed had been taken from him in the struggle without his realizing it. He did not want to run the risk

of letting Harris go for the sake of reaching for a holster that might be empty. This line of reasoning seems to reconcile his perception of a deadly threat with his choice not to involve his own gun in response. (Giles, for his part, eventually became aware of the gun after being warned by Wingfield. He too chose to focus on trying to control Harris's arms, while intensifying his efforts to gain compliance by punching Harris in the back.)

As for the tactic Officer Wingfield used that involved a neck restraint, he described it as an improvised effort to use one arm and simultaneously impede Mr. Harris's breathing and pin his head to the ground to limit his visual field. In his view, this was not deadly force but rather an effort to deplete Harris's ability to resist as the officers waited for back up to arrive. He did not consider his one-sided restriction to constitute a standard carotid hold. Nor did he believe it would have been sufficient to render Harris unconscious, even if it had gone on for longer than the 30-40 seconds of his estimated application. Though he did hear Mr. Harris refer to being choked at one point in the struggle, he considered Harris's ability to speak as indication that he was continuing to get air.[9] He thought the restraint had been helpful in controlling and weakening Mr. Harris as he waited for the additional officers' assistance, but had not endangered him to the level of deadly force.

Officer Wingfield's reasoning makes partial sense, to the extent that his tactic was clearly distinct from the standard carotid hold in both its intention and its execution. The Training analysis for the case also determined that it was not a carotid hold.[10] From there, and importantly, Training also included the opinion that the technique used by Wingfield "should not be considered a use of deadly force."[11]

We see it differently.

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[9] While not a major turning point in this case, it should be noted that the notion that "If you can talk, you can breathe" has been discredited as an oversimplification that does not obviate potential safety concerns.

[10] Presumably, part of the reason the analysis stopped there is that the carotid hold is the only neck restraint currently considered deadly force by PPB General Orders.

[11] The sustained knee to the neck used in the George Floyd murder was also not technically a carotid hold, but by no means could it be argued that it was not a use of deadly force.

The action did constitute deadly force, insofar as it was a neck restraint for the purpose of blocking the airway of the subject. That it was only partial and not lastingly harmful to Harris (who was checked and cleared by medical personnel at the scene) does not obviate the inherent dangers associated with restricting airflow and applying force in the neck and throat area. However, we agree that the attendant circumstances presented to Officer Wingfield indicated a deadly force situation, which under current policy would have allowed his efforts to restrain Harris' airflow.

Officer Wingfield in fact made several judgments during the encounter that were meant to de-escalate the situation and that ultimately were safer than a shooting would have been. It should, however, be clear to Bureau officers that, per policy, neck restraints of any kind should be limited to a situation in which deadly force would be authorized.

It also would have been preferable for Training to go beyond its conclusion that the technique had been neither a carotid nor deadly force. The Internal Affairs investigators had contacted Training during the review process to ask whether the technique used by Wingfield was something the Training Division taught. They were informed that it wasn't. While making allowances for the improvisation prompted by the difficult circumstances, it would still have been important for training to assess (or confirm) effectiveness and consider possible alternatives.

Importantly, the passage of time has changed the landscape with regard to this issue. The George Floyd case – which post-dated this incident by two years – galvanized a national reconsideration of all neck restraints, and Oregon joined other states in responding legislatively. A new state law that was passed in the summer of 2020 (HB 4301) banned the use of pressure on the throat or neck to restrict breathing or blood flow, except when deadly force is justified.

PPB's current policy 1010.00 aligns with these limitations. It makes clear that neck holds of various kinds (and not just the carotid hold) are to be considered deadly force and restricted accordingly.

As for the rest of the incident, the officers' actions were all validated in the subsequent review as being both in policy and tactically effective. The initial approach by the officers put them in an unenviable position in relation to Mr. Harris and his former girlfriend – they saw each other from what Officer Wingfield estimated was 30 to 40 yards away, and they were

concerned with the possibility of his fleeing on foot. They separately adopted low-key forms of communication that were intended to put Mr. Harris more at ease (though he was clearly wary from the beginning). When their initial efforts at controlling Mr. Harris physically were met with resistance, they attempted to take him down to the ground. The force that ensued from that point was a function of their difficulty in overcoming his resistance – a problem that was obviously exacerbated by their dawning awareness of the gun.[12]

As for the two officers who arrived last to the scene and ultimately effectuated the handcuffing, their actions were also found to be justified and within policy. Officer Miller's role was limited to grabbing Mr. Harris's arm to help with handcuffing. Officer Harding had first delivered multiple punches, but he was aware of the gun and stated the situation was not controlled when he arrived to help.

Per policy, the review also assessed the supervisory response and found that Acting Sergeant Sawtelle (who was soon joined by another sergeant on scene) took appropriate steps to ensure Mr. Harris's medical wellness, to initiate a formal investigation and to handle the involved officers appropriately in terms of separating them and other post-force protocols.

One issue that was not overtly addressed was the use of profanity by Officer Giles, which he had acknowledged in his interviews. He explained it as being a function of both adrenaline and his efforts to impress upon Mr. Harris the seriousness of his own intentions. While it was good for the issue to be identified and inquired about during questioning, it should have been directly addressed in the Training analysis and Review Board assessment of the incident.[13]

> RECOMMENDATION 1: The Bureau's holistic review of any critical incident should identify and address issues relating to officers' language and overall professionalism.

[12] Interestingly, and to his credit, Officer Giles offered thoughtful reflections on how the outset of the call could have been handled more effectively. He said that, in hindsight, the nature of the call and the known circumstances of the subject might have made it prudent to wait for an additional officer or two before engaging.

[13] Notably, Mr. Harris himself cited PPB profanity – apparently with some justification – as being a basis for his own perception of improper officer aggression.

Lastly, we noted that there were other witnesses to the encounter whose perspective was not included in the investigative materials. This may have been due to an unwillingness to cooperate, and our understanding is that these individuals had turned against the officers by the end of the encounter. But the former girlfriend of Mr. Harris who was at the scene did provide detectives with information as to the identities of the relevant parties, and there is no documentation as to whether efforts were made to elicit statements from them.

> RECOMMENDATION 2: PPB should work to gather statements from known witnesses to critical incidents, or should clearly document any unsuccessful efforts at doing so.

Timeliness of Investigation and Review

This case took 257 days to complete, with the long delay attributed in part to the uncertainty about how it should be classified. More specifically, part of this was a function of the delayed decision to incorporate each officer's use of force into the formal review, which initiated a second stage of the investigative process some four months after first. The IA investigation itself was not completed until 179 days past the incident.

October 10, 2018 ◦ Samuel Rice

Dispatch received a 911 call reporting a fight between two subjects in a convenience store. Two uniformed officers initially responded and later identified Samuel Rice and another man as those involved in the fight. A woman, later identified as Rice's girlfriend or fiancé, was accompanying Rice. The fight ostensibly occurred when there was a dispute between the girlfriend and the other person over the question of who was next in line.

By the time officers arrived, they observed Mr. Rice and his girlfriend across the street from the store. Officers learned that during the initial altercation, Mr. Rice had been armed with a knife and had tried to stab the person with whom he had the fight. Officers were advised that the other man had successfully taken the knife away and placed it on the store counter, but Rice then retrieved it and walked out of the store.

Responding officers attempted to speak to Mr. Rice at various times but were not successful; they reported that Rice would either not respond at all or would yell "nonsensical" things. Rice then walked to one of the motel rooms where officers eventually learned that he and his girlfriend had been staying, yelling at his girlfriend to follow him, which she did. Officers observed the girlfriend walk past the room while Rice used his shoulder to force the door open and enter the room. Rice then stepped back outside, grabbed the girlfriend from behind, pulled her into the room, and shut the door. He then used a mattress to barricade the front door to the motel room.

Officers remained stationed outside the apartment while they assembled resources and coordinated their next steps. Mr. Rice called 911 and indicated that he wanted officers to leave while also expressing concern about the treatment of his fiancé. His call included irrational comments. The call ended after the girlfriend was heard telling Rice to hang up the phone. PPB's Crisis Negotiation Team ("CNT") and Special Emergency Response Team ("SERT") were activated and responded.

CNT responded with its van and established a communications post. A negotiator talked with Mr. Rice in an effort to get him to leave the motel

room voluntarily. SERT directed officers to evacuate all nearby motel rooms and set up team members on either side of Rice's room. A command post was set up nearby from which to direct operations.

SERT Officer Kelly VanBlokland was positioned along with another officer in the bed of a truck parked in the motel lot. The officer observed Mr. Rice at the motel room window as he flipped the officer off and then covered that window. When Rice appeared at another window, Officer VanBlokland fired one round from his AR-15 rifle, striking Rice in the eye and killing him. SERT members who had been positioned on either side of Rice's motel room then forced entry. SERT medics pronounced Mr. Rice dead at the scene.

Apparently as the SERT and CNT teams were staging and endeavoring to talk with Mr. Rice, one of the responding officers, apparently on her own initiative, attempted to establish communication with his girlfriend. She reported that when she arrived on scene, she went to the motel office to retrieve a phone number for Rice or his girlfriend. She called the room number from the office phone and someone picked up but said nothing. The officer reported she could hear Mr. Rice screaming from across the room to hang up the phone. She asked the person on the other end whether he or she was okay, but they did not respond. The officer said she then heard a click and was disconnected.

The officer wrote in her report that she then texted the phone number listed on the couple's room application, "[Name of girlfriend], are you ok?" The officer followed with a text: "We need to know you are safe and we'll take a huge step back." The officer reported that 12 minutes later, she received a text reply: "Yes, go away". The officer had joined CNT in its van when she received another text: "Go away". The officer wrote that she was in the process of reporting her communications to CNT when she was told that Rice was down.[14]

On scene officers, including a responding sergeant, had been advised that days earlier, PPB had responded to a similar situation involving conflict between Rice (who was also at that time wielding a knife) and the

[14] In part because this officer was not interviewed as part of the investigation, the timing of the officer's actions in conjunction with the SERT operation is not clear. It is also unclear whether the officer was instructed to attempt to make contact with the occupants or whether she self-initiated these efforts.

girlfriend. Officers during that earlier incident had disengaged when the girlfriend advised she was all right.

The grand jury returned a no true bill regarding the incident. The Internal Affairs investigator recommended no violations of policy. The Commander's memorandum deferred completely to the recommendations by the IA investigator. The Review Board found the shooting in policy and had no additional recommendations. The Chief found all incident and post-incident decision making consistent with Bureau policy.

Timeline of Investigation and Review

10/19/2018	Date of Incident
11/30/2018	Grand Jury concluded
12/26/2018	Internal Affairs investigation completed
2/1/2019	Training Division Review completed
5/23/2019	Commander's Findings completed
6/27/2019	Police Review Board meeting
6/28/2019	Case Closed

OIR Group Analysis

Insufficient Investigation and Analysis of Efforts to Communicate with Hostage

During the initial 911 call, Mr. Rice expressed agitation about the treatment of his fiancé in the midst of other, irrational comments. The call ended when the fiancé told Rice to hang up the phone and Mr. Rice complied.

As noted above, one of the initial responding patrol officers prepared a supplemental police report documenting her actions. Those efforts resulted in the girlfriend picking up the motel room phone but then not speaking. More significantly, the officer documented receiving two texts, one advising that the girlfriend was safe and to go away (as the officer suggested they would do if they learned that the girlfriend was safe) and another text telling the officers to leave.

This important information by this officer about potential contact from the girlfriend was not mentioned anywhere else in the investigative report, nor were the text messages included in the report (even though the officer indicated she had downloaded them). The officer was not interviewed about her actions. Significantly, in their interview with the girlfriend, detectives did not ask whether she was the one texting with the officer and whether she had advised them via text that she was safe and to "go away".

In his interview, the initial incident commander noted the earlier call involving Mr. Rice and his girlfriend, and said PPB had not similarly disengaged in this incident because they were unable to contact the girlfriend. But investigators did not ask the anticipated follow-up questions about whether the incident commander or the CNT negotiator was aware of the patrol officer's attempts to reach the girlfriend via phone call and text messages,[15] or how knowledge of those communications would have shaped operational planning. The failure to follow up on this information was a serious misstep in the investigation and review of this case.

There was likewise no mention of this communication in the Bureau's review of the incident. Apparently, critical information about a possible repeated contact with the girlfriend minutes before the application of deadly force was not forwarded to responding officers or considered in analyzing the incident. Nor, as detailed below in the Training Division Review, was this potential contact, or the 911 call, considered in evaluating the performance of responding officers and the decision to use deadly force.

[15] There is a possibility that the texts may have been written by Mr. Rice; that possibility could have been explored had there been a more substantial investigation into them.

Shot of Opportunity

During her interview, the on-scene critical incident commander said that a "shot of opportunity" – where a sniper is authorized to shoot a subject on sight if or when the opportunity is presented – is used in extreme circumstances, such as to rescue a hostage who is in grave danger. However, the incident commander said that in this case there was no permission given for a "shot of opportunity" and that responding officers (including SERT) were operating under standard rules of engagement.[16] Standard rules of engagement require that officers who use deadly force must articulate a basis for using lethal force consistent with PPB use of force policies.

Training Division Review

The Training analysis identified the following threats and risks to the potential hostage as described by the shooter officer:

- Rice was armed with a knife.
- Rice had pulled the girlfriend into the motel room and there was belief she was being held against her will.
- After the girlfriend had been pulled into the motel room, police did not see her again until after the use of deadly force.
- Negotiators had attempted to speak with the girlfriend but she did not speak to them and, in contrast, she had spoken with police during previous incidents involving Mr. Rice.
- Mr. Rice was barricading the motel room to prevent police from entering or seeing inside.
- There was a history of domestic violence between Rice and the girlfriend.

[16] In contrast, a SERT supervisor told investigators of the "window of opportunity" provided to the snipers in this case as perhaps the safest way to end the conflict. But no shot of opportunity was either requested or authorized in this case.

- Mr. Rice was not engaging in effective communication with negotiators.
- Since Rice was armed with a knife, he could kill his girlfriend in a quiet manner unknown to the SERT officers in the vicinity.
- During the last conversation with negotiators, Rice had demanded that police leave or he would slit her throat.

The Training analysis also noted the risk to SERT team members:

- The barricading of the room limited the ability for a fast entry.
- The plan for an explosive breach into the room was not foolproof.

Unfortunately, the Training analysis only evaluated factors supporting the risk to the girlfriend and responding officers. The Analysis failed to consider:

- The fact that days earlier, responding officers had been able to de-escalate the situation (even though Rice was armed with a knife) after they backed off and were advised by the girlfriend that she was not in harm's way.
- The fact that the girlfriend may have texted in this case that she was ok and twice advised the officers to leave.
- The fact that during the 911 call made by Rice, the girlfriend told Rice to hang up the phone and he did, indicating that the girlfriend had some agency in the relationship.[17]

The Training analysis also accepted speculative conclusions made by the shooting officer about the threat level presented and ignored other facts that mitigated against the use of deadly force.

For example, Training concluded that officers had probable cause to arrest Rice for attempted assault and kidnapping and that when Rice first presented himself in the window, Officer VanBlokland would have been justified in using deadly force at that point. Training opined that after Rice told negotiators that the police had to leave or he would slit his girlfriend's

[17] Because of the failures in effective communication between responding personnel, these facts, or at least the details, were likely not known by Officer VanBlokland.

throat, the options for successful negotiations were greatly reduced. If the shooting officer had chosen not to use deadly force when Rice reappeared, Training then speculated that Rice likely would have closed the second window and eliminated any opportunity for the officer to take a shot.

Training then noted that Officer VanBlokland said that he believed the girlfriend was in immediate danger, based in part on a SERT sergeant's communication via radio that if they heard yelling from inside, the team would make entry in order to save the girlfriend's life.[18]

The Training analysis noted that when Mr. Rice presented himself in the bathroom window, Officer VanBlokland said he believed this was his one opportunity to resolve the incident safely for the girlfriend. The officer said that Rice was looking directly at him with a "thousand yard" stare intended to see whether the police had left yet. Officer VanBlokland said that he "knew" that because the police had not left, Rice was going to kill the girlfriend, so he decided to use deadly force. The Training analysis concluded that the use of deadly force was consistent with Training and policy.

Training accepted Officer VanBlokland's speculation – based on the "thousand yard stare" – that he "knew" that Mr. Rice was about to kill his girlfriend. Training considered no other possible interpretations of this perceived stare – including the possible association with a mental health crisis – and did not objectively weigh its impact on the threat assessment.

Most importantly, Officer VanBlokland was apparently the only Bureau member on scene who saw the necessity in using deadly force at that moment. At the time, there was a high ranking official on scene as the incident commander, along with a number of other SERT and patrol supervisors, SERT officers, and the Crisis Negotiation team all working to address the situation short of deadly force. In fact, as noted above, an on-scene supervisor expressly radioed to the team (which Officer VanBlokland admittedly heard) that they would make immediate entry as a rescue action, but only if they heard screaming or the sounds of a struggle

[18] Officer VanBlokland was interviewed one day after the incident, a noted improvement from past delays in obtaining statements from shooting officers. However, as we have stated numerous times, best investigative practices are to obtain a statement on the date of the incident and before the officer is sent home.

from the motel room. Except for Rice making himself visible, closing the windows of the bathroom, and engaging in a “thousand yard” stare, Officer VanBlokland had no additional information beyond what the rest of the team knew. Yet the Training analysis (or any other analysis by those responsible for reviewing this incident) did not address whether these virtually negligible additional objective factors were sufficient to warrant an application of deadly force, nor did it consider the full panoply of factors inherent in this scenario.

Communications Issues

This incident was marked by at least three significant communications breakdowns:

First, as detailed above, a responding officer had gotten through to Rice and/or his girlfriend via the motel room telephone and had a subsequent exchange of text messages that suggested that the girlfriend did not feel threatened that none of the other officers on scene were apparently advised about prior to the shooting.

Second, CNT was still intent on trying to resolve the situation through communication with Rice and his girlfriend, but this was apparently not communicated to Officer VanBlokland, who formed the belief that the girlfriend’s life was in immediate danger.

Finally, Officer VanBlokland fired at Mr. Rice without successfully communicating his observations and intent to use deadly force to the incident commander or any supervisors. In essence, despite a cadre of supervisors on scene who saw no necessity in using deadly force at that juncture, Officer VanBlokland decided on his own to end Rice’s life. As the shot rang out, responding officers were not aware of the reasons the shooter officer decided to use deadly force since neither he nor his partner had successfully communicated that intent to on scene supervisors and officers.

Officer VanBlokland said that he attempted to get on the radio to advise the other responding officers and supervisors that he intended to take a shot if he had the opportunity, but got a “honk back,” indicating that the channel was full with competing transmissions. In his interview, Officer

VanBlokland said he advised his partner that he was not able to put out a transmission over the radio.[19]

When asked why the officers did not use their cell phones to call a supervisor to communicate their intent, the partner said that they wanted to communicate their intent to the whole team rather than one individual. This response is not logical; it suggests because they were not able to communicate with the whole team the snipers decided not to communicate with *anyone* on the team before taking independent action.

The investigation did not engage in any forensics in an effort to corroborate whether the snipers attempted to use the radio. And in contrast, earlier in the scenario, the partner officer had no difficulty communicating with SERT command. For example, he asked whether it was acceptable if they positioned themselves in an elevated setting where they would be visible to Rice and received a positive response. Moreover, immediately after the shot was fired, Officer VanBlokland had no difficulty immediately communicating with others on scene.

Even if Officer VanBlokland had attempted to radio his intent and was unsuccessful, this was a significant equipment limitation that should have been identified and addressed by the Bureau's review process. Because the limitation wasn't addressed, SERT did not develop a plan to ensure that snipers would have a way to effectively communicate with incident command during future operations. It is incumbent upon the Bureau to consider that now.

> RECOMMENDATION 3: The Bureau should review its rules of engagement for supervisors and officers to address situations in which equipment limitations prevent officers from communicating with incident command, specifically to set guidelines governing how communication limitations impact officers' authority to take independent action and use deadly force.

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[19] In his interview with detectives, the shooter officer's partner officer did not report observing any such attempt or Officer VanBlokland's articulation about not being able to transmit over the radio. Rather, in his interview with Internal Affairs, the partner said *he* tried to put out over the radio that if they saw Rice again, they intended to shoot him but said that he got a honk back and was unable to transmit the message.

Failure to Include Documents Relating to Previous Contacts

As noted above, the sergeant who served as the initial incident commander[20] was aware of at least one recent prior contact with Mr. Rice days before where he had threatened violence toward his girlfriend. The sergeant told investigators that he had been on scene for that earlier disturbance, during which Rice came to the door with a knife. In that incident, they were able to eventually get Rice to calm down. They contacted the girlfriend by phone, and she told them she was okay. After receiving that information, officers disengaged and eventually walked away.

In fact, early in this incident, a radio transmission was broadcast to responding officers to the effect, "in the past, [Rice] has de-escalated if we back off."

The initial incident commander said that the prior incident was different in that they were able to communicate with the girlfriend and could see a difference in Rice's demeanor when they backed away. He said that if the girlfriend in the second incident had been able to say "no, he's not threatening me, I'm fine," they might have gone in a different direction. However, as noted above, an officer *had* received two texts (potentially but not definitively from the girlfriend) advising officers that she was okay and to go away.

Neither the investigators nor those responsible for reviewing the incident made any effort to compare the two events to draw any lessons that could be learned about why one incident ended with officers leaving the engagement while this event ended with an officer killing the involved individual. A more thorough review would have included an analysis of the Bureau's different responses to the two scenarios.

[20]Eventually, the initial incident commander was replaced by an individual of higher rank.

RECOMMENDATION 4: In an officer-involved shooting investigation, when there is reference to an earlier incident involving the same parties, reports and other information relating to that earlier event should be collected and included in the investigative file and discussed as part of the overall analysis.

Timeliness of Investigation

This case was completed in 262 days, almost 100 days past the 180-day deadline agreed to as a result of the settlement agreement with the U.S. Department of Justice. In prior reports, we have seen extensive analysis of why a case was late and what entities were responsible for going past deadlines. We did not see such an analysis in the investigative materials provided with this incident.

October 19, 2018 ◦ Jason Hansen

A Clackamas County K-9 unit was on patrol when the deputy saw a parked vehicle and learned that the car had been reported stolen. After the car drove away, the deputy activated his overhead lights in an attempt to conduct a traffic stop, prompting the driver to speed off while the deputy engaged in a vehicle pursuit. The car eventually came to a stop at a dead end. A female was at the open passenger door but the deputy did not see the driver. The female was detained and told the deputy that the male driver (later identified as Jason Hansen) had fled on foot.

A nearby resident told responding deputies that a person had just run through his backyard. Deputies set up a perimeter. Portland Police Bureau K-9 Officer Kameron Fender was in the area and assisted Clackamas County by taking a perimeter position. Officer Fender contacted the Bureau of Emergency Communications (BOEC) service net to have himself assigned to the call.

Officer Fender was outside of his vehicle and saw an individual, eventually identified as Mr. Hansen, walk out of a yard or driveway in the direction of the officer. Officer Fender used his flashlight to illuminate Hansen. At this time another Clackamas County deputy arrived on scene. Officer Fender began to talk with Hansen but did not believe he had probable cause to arrest him as the suspect.

Officer Fender later told investigators that Mr. Hansen was being defensive to his questions, was sweaty (even though it was night-time and cool outside), and had turned his body partially away from the officer so that he could not see Hansen's right hand. Based on these additional observations, Officer Fender now believed he had probable cause to arrest Hansen for the crime of felony eluding.

Officer Fender asked Mr. Hansen to show him his hands and Hansen raised both his hands above his shoulders. Officer Fender asked Hansen to sit down but Hansen did not follow these instructions. By now, another Clackamas deputy had just arrived on scene.

Officer Fender and the first Clackamas deputy began to walk toward Mr. Hansen, but the subject began to hurriedly walk away. As Hansen walked away, his hands moved towards his waist area and Hansen drew a firearm, turned back towards the officers, and fired one round in their direction. As Hansen fired at the officers, Officer Fender drew his firearm, moved to his left, and fired three rounds at the subject. Hansen stumbled to the ground.

The second Clackamas deputy referenced above pulled up parallel to Mr. Hansen and fired two rounds at Hansen just after Hansen stumbled to the ground and while he was still holding the firearm. The second deputy ordered Hansen to drop the weapon at which time Hansen tossed the gun away from him. After Hansen tossed the gun, the second Clackamas deputy exited his patrol car and ordered Hansen to not move and put his hands out. The two deputies and Officer Fender then moved towards Hansen who was still lying on the ground.

Officer Fender and a third Clackamas County deputy approached and handcuffed Mr. Hansen while another deputy provided lethal cover. Officer Fender and the third Clackamas County deputy then handcuffed Hansen. While Officer Fender was securing Mr. Hansen, another Clackamas County K-9 team arrived and the dog bit Officer Fender's right leg. It took the deputy approximately 30 seconds to get his K-9 to release Officer Fender from the bite. Officer Fender was transported by ambulance to a local hospital with a significant dog bite wound.

Mr. Hansen received gunshot wounds to his upper left leg, upper left back, and a graze wound to his right forearm. Hansen also said that he received a dog bite wound to his upper chest area.[21]

Paramedics were summoned to provide medical care for Hansen, who survived his gunshot wounds.

The District Attorney presented this case to the grand jury, which concluded the use of deadly force by Officer Fender and the Clackamas County deputy was legally justified and charged Mr. Hansen with

[21] Officer Fender told PPB that he did not see the K-9 bite Hansen. As discussed further below, PPB's failure to obtain photographs of Hansen's injuries and medical records leave a significant investigative gap relating to this issue.

numerous criminal offenses. Eventually Hansen pleaded guilty to two counts of attempted murder and was sentenced to a 10-year prison term.

The Police Review Board found that the shooting by Officer Fender was within policy and that all post-incident procedures were appropriate. The Chief concurred with the Review Board findings.

Timeline of Investigation and Review

10/19/2018	Date of Incident
11/27/2018	Grand Jury completed
12/27/2018	Internal Affairs Investigation completed
2/5/2019	Training Division Review completed
2/27/2019	Commander's Findings completed
4/30/2019	Police Review Board meeting
6/28/2019	Case Closed

OIR Group Analysis

Training Division Review

The Bureau's Training analysis determined that Officer Fender demonstrated sound and effective tactics in assisting Clackamas County by taking a perimeter position and identifying options on how to respond when he sighted Hansen, that he had no time to take any other action other than a deadly force response and appropriately considered his backdrop in firing.[22] Training further found that Officer Fender took control of the custody team after the shooting, effectively articulating each role.

[22] We also note that Officer Fender fired a limited number of rounds (three) to respond to the threat of an active shooter.

Training also considered and positively recognized Officer Fender's attempts to de-escalate the situation by using time, distance, cover and tone of voice.

Training identified one communications issue where Officer Fender's actions could have been more effective (though were not inconsistent with training). When Fender heard Clackamas County's request for air support over dispatch, he contacted the BOEC service net to be attached to the call as he headed towards the pursuit. The Training analysis noted that officers are trained to use the MDC when possible because it is the most effective way to communicate with other Bureau members. According to Training, if Officer Fender had updated his status over the air, it might have eliminated some of the confusion of who was involved and may have alerted a precinct sergeant that a Portland officer was responding to this incident. Training recommended that the Bureau's K-9 unit review their procedures on how officers notify BOEC of their status and location when assisting outside agencies.

To its credit, the Training Division identified an important communication issue and suggested a systemic remedial measure to rectify the situation. However, the documents relating to this incident provide no indication that this recommendation was formally considered, let alone implemented. The K-9 unit should review its procedures as Training recommended. And as we discuss in further detail later in this report, the Bureau should develop specific protocols to ensure that recommendations like these are appropriately considered.

> RECOMMENDATION 5: The Bureau's K-9 unit should review its procedures for how officers notify others of their status and location, as recommended by the Training Division.

Issues with Clackamas County K-9

As Officer Fender secured Mr. Hansen, an off-leash Clackamas County K-9 bit him and held the bite for 30 seconds before the deputy was able to get the dog to release. Mr. Hansen may also have been bit by the same dog. But other than a passing reference, there was little mention and no analysis of the safety implications of these inappropriate bites. In addition

to the serious injuries to Officer Fender,[23] the behavior of the dog and its insertion into the apprehension of Hansen created serious challenges for the responding officers.

PPB assumed control of the critical incident investigation but detectives failed to interview the K-9 handler who had allowed his dog to enter the scene unleashed and both injure an officer and impede efforts to address the aftermath of an officer-involved shooting (handcuffing, searching, medical attention for the subject). The Training analysis also ignored the insertion of the untethered K-9 when discussing tactical challenges, including the apparent inability of the K-9 handler to get his dog to immediately come off the bite. Finally, while clearly Clackamas County bears the burden of accountability with regard to its K-9 handler, there was no apparent inquiry by the Bureau into whether there was any accountability or remediation designed to reduce the likelihood of any future problematic behavior by off-leash police dogs.

When tactical issues of a joint operation present themselves, even when they involve the performance of the sister agency, the Bureau should investigate and evaluate the whole incident in the interests of assuring safety and security in future tactical operations. If the Bureau fails to gain the cooperation of the other agency, it should at least document its attempts to include statements from members of the other agency in its investigation.

> RECOMMENDATION 6: The Bureau should revise its protocols to ensure that investigators endeavor to collect facts relating to all aspects of a deadly force event, including post incident challenges, even if the performance involves a law enforcement officer from an outside agency.

[23] In this case, Officer Fender was interviewed approximately three weeks after the incident. However, the delay in interviewing Officer Fender was understandable in that he had been severely injured by the off-leash police dog who intruded onto the crime scene. PPB protocols provide for such a delay and the decision to wait until the officer was sufficiently recovered from his injuries was understandable and appropriate.

Investigation and Review

Request for Follow-Up from Chief

After the Review Board recommendation and internal investigative report was presented to the then-Chief, she requested follow-up on several issues:

- Were injuries to subject consistent with the evidence and confirm bite injury to the subject?
- Round count consistent with casing recovery count?
- Any other uses of force?
- Were there any discrepancies?

Internal Affairs responded to these inquiries as follows:

- Only one round recovered from subject's body during surgery. Injuries were consistent with gun-shot wounds.
- As to the dog bite, the subject had a bandage on his chest when talking with investigators and advised that it was covering a bite wound inflicted by the K-9. There were no photographs in the investigative file of the subject while in the hospital. Investigators contacted Clackamas County and learned that they also did not take any photographs of Hansen's injuries.[24]
- The recovered casings were consistent with the round counts.

The follow up by the Chief is the first time we have seen engagement to this level and the request for clarity is a promising development. No investigative report will likely answer all questions a reviewing authority may have and the fact that further information was requested shows a level of engagement consistent with best review practices.

[24] We discuss this gap in the investigation below.

Failure to Document Subject's Injuries

As noted above, PPB's investigation into this incident failed to photograph Mr. Hansen's injuries or obtain medical records describing his injuries. As a result, questions raised by the Chief about whether Hansen was bitten by the dog had to rely entirely on Mr. Hansen's statement. A review of PPB's current General Orders indicate that they do not specifically require photographs of injuries or collection of medical records. To avoid similar deficiencies in the investigative report, we recommended in our last report (Recommendation 12) that the Bureau revise its policies to expressly set out the requirement. We reiterate that recommendation again here.

> RECOMMENDATION 7: The Bureau should modify its protocols to require investigators to both photograph injuries and collect medical records in cases where individuals are injured but not killed in officer-involved shootings, or to document the reasons for their inability to do so.

Timeliness of Investigation

This case was completed in 274 days, almost 100 days past the agreed to 180-day deadline as a result of the settlement agreement with the United States Department of Justice.

December 7, 2018 ◦ Ryan Beisley

Just after 5:00 PM on a Friday, the subject (later identified as Ryan Beisley) alarmed employees and patrons in a Starbucks with his confrontational behavior. The store manager asked him to leave, but he refused and challenged her to call the police. Mr. Beisley walked behind the service counter, as the manager instructed other customers to leave and directed the staff into the storage area at the back of the store. Mr. Beisley attempted to get into the storage area – secured only by a swinging door that does not lock – while the manager called 911. Employees held the door shut while Mr. Beisley attempted to push through it.

Two officers – Edward Johnson and John Shadron – were dispatched to the call. The BOEC dispatcher reported to responding officers that Beisley was yelling and appeared to be drunk; officers also learned that the employees were in a storage room that did not lock, and that the subject was trying to push his way in. Officer Johnson arrived first, about five minutes after the first 911 call, and immediately entered the Starbucks to confront Mr. Beisley. Mr. Beisley remained behind the counter, with his hands in his jacket pockets. Officer Johnson withdrew his Taser and ordered Mr. Beisley to take his hands out of his pockets. Beisley did not comply, and instead yelled “fuck you” as he turned toward the officer. Johnson broadcast that the subject was uncooperative and requested cover officers to step up their response. Dispatch added Officer Lucas Brostean to the call. Officer Johnson also requested a medical response because of Mr. Beisley’s behavior.

Officer Shadron arrived about a minute later and joined Johnson inside the coffee shop. Mr. Beisley did not respond to the officers but continued to push on the door to the back room. He then turned and moved quickly from behind the counter toward Officer Johnson, who deployed his Taser

once, to no effect.[25] Mr. Beisley withdrew a gun from his pocket and turned and moved toward Officer Shadron. Shadron saw the gun pointed at him and backed away. He said when interviewed that he withdrew his firearm but did not immediately fire because he realized his back stop was the storage room where the Starbucks employees were hiding. Officer Shadron continued moving away, rounding the corner of the counter, while Mr. Beisley continued to point his gun at him. Officer Shadron fired three times at Mr. Beisley, who fell with his chest on the ground.

Officer Johnson broadcast "shots fired" and dispatch requested both a sergeant and medical response. Officers Johnson and Shadron addressed Mr. Beisley and ordered him to show his hands. He at first moved his hands out to the side, but then brought them back under his body. Because they could not see the gun, the officers made the decision to back out of the store rather than immediately take Mr. Beisley into custody.

The officers moved to positions of hard cover outside the building but within view of Mr. Beisley. They requested dispatch to contact the employees in the storage area, and dispatch reported back that the storage room had no back exit, so the employees had no way to leave the store without going back through the counter area.

As they monitored Mr. Beisley from outside and waited as additional cover officers arrived and positioned themselves behind cover outside the store, Mr. Beisley got up, picked up the gun, and walked behind the counter. He tried again to push open the storage area door, but the staff continued to hold it shut. Officer Shadron then went to the front door of the Starbucks to draw Beisley's attention away from the employees. Mr. Beisley eventually came toward Officer Shadron and exited the store with the gun up at his shoulder level, pointed at officers staged outside the store. Two officers had positioned themselves near the front door: Officer Dustin Lauritzon, who had seen others with handguns and so armed himself with a shotgun, and Acting Sergeant John Sapper, who had just arrived on scene and was being briefed by Lauritzon. Both had positions of cover behind a patrol vehicle parked directly in front of the Starbucks. Officer Brostean was positioned to the west, behind a different car. All three

[25] Data from the Taser show the weapon cycled for five seconds, but with poor connectivity, suggesting that the probes did not connect with Mr. Beisley's skin, likely due to the thickness of his jacket.

described their back stops, with awareness of their angles and the need to avoid firing in the direction of the storage area. All three fired their weapons as Mr. Beisley exited the store. Acting Sgt. Sapper fired six rounds, Officer Brostean fired three rounds, and Officer Lauritzon fired six shotgun slugs.

Mr. Beisley fell to the ground but continued to move around while officers shouted commands. Under the direction of a different sergeant, officers coordinated a plan. They located the gun several feet from where Mr. Beisley was laying, then advanced to secure it and take Mr. Beisley into custody. About two minutes after the shooting, seven officers approached. While Mr. Beisley struggled briefly, they pinned him to the ground and quickly secured him. The weapon officers retrieved was a BB gun that looked similar to a Beretta. Mr. Beisley had been shot twice – in the upper arm and leg – and was transported to the hospital with non-life threatening wounds. Bullets and shotgun slugs struck the door, windows, and outside walls of the shop; none traveled into the area where the employees had barricaded themselves.

Bystander video captured portions of the shooting that occurred outside the Starbucks, as well as the effort to subdue and arrest Mr. Beisley.

After reviewing the case, the District Attorney's Office determined there were legal bases for the use of deadly force and decided not to present to the case to the Grand Jury. It issued a memo declining prosecution on January 29, 2019.

The Police Review Board met in June 2019 and determined that all officers' and supervisors' actions were within policy in all areas reviewed. Some Board members discussed the possibility of recommending that Training review its protocols regarding deployment of shotguns, but the Board did not have a quorum at that point of its meeting and could not make a formal recommendation. The Chief concurred with the Board's findings.

Timeline of Investigation and Review

12/7/2018	Date of Incident
1/29/2019	Prosecution decline memo
4/21/2019	Training Division Review completed
4/23/2019	Internal Affairs Investigation completed
5/17/2019	Commander's Findings completed
6/12/2019	Police Review Board meeting
6/13/2019	Case Closed

OIR Group Analysis

Initial Contact and Use of Force

Mr. Beisley's behavior inside the Starbucks was sufficiently alarming to cause the store manager to clear out other customers, usher employees into a storage area, and call 911. When Officer Johnson arrived, he recognized the urgency of the situation and entered the store without waiting for backup. While the Training Division Review notes that the officer erred by not communicating his plan, it found that the decision to enter and confront Mr. Beisley was appropriate given the risk presented to the employees still in the store.

Once in the store, Officer Johnson and later Officer Shadron both report their efforts to de-escalate the situation. Officer Johnson had a Taser drawn but not pointed at Mr. Beisley, and both kept their distance and attempted to communicate with him, to no apparent effect. Officer Johnson deployed his Taser when Mr. Beisley came out from behind the counter and moved toward Officer Shadron. The Taser did not work as intended, likely because the probes did not get through Mr. Beisley's coat to make contact with his skin. Each of these decisions and actions was appropriately and thoroughly evaluated in the Training Review.

After the Taser deployment, Mr. Beisley continued to advance toward Officer Shadron, now pointing what gave every appearance of being a firearm. The officer withdrew his own firearm as he backed away, but recognized the storage room door was directly behind Mr. Beisley. So he moved around the corner of the counter where he could fire on Mr. Beisley without also firing directly at the Starbucks employees. He fired three rounds, striking Mr. Beisley – likely in his arm – and causing him to fall to the floor. The Training analysis found that Officer Shadron's awareness of his back stop and ability to quickly adjust his positioning to protect bystanders in this situation was tactically sound and commendable.

Officers' Decision to Exit Store

After Mr. Beisley went down, the officers gave commands for him to show his hands so they could safely approach and take him into custody. He briefly put his arms out, but then drew his hands back underneath his body. Because the officers could not see his gun, it was not safe to close the distance and make themselves more vulnerable to a possible shooting. They decided to exit the store to find a position of cover while maintaining visual contact with Mr. Beisley. About this decision, Officer Shadron stated in his interview with IA:

> *I'm hoping he's just going to stay down. I'm giving him direction to stay down but I feel like we're going to be forced to shoot him again if he tries to turn and shoot us or that he will try to shoot us again. So I tell Officer Johnson we need to back out. We need to get ourselves cover . . .* [lines 384-387]

The IA investigator pushed back on this reasoning a bit:

> *[B]ut knowing now that he did get up and pick up a firearm, would that have changed your mind out at the scene and maybe just stay sort of guns on him and not give ground . . . ?* [lines 720-721]

The officer replied that he "would've done everything exactly the same."

The Training analysis accepted the officer's explanation and declared the decision to leave the store to find cover to be consistent with training on post-shooting tactics. About the employees remaining in the store,

Training stated the officers “knew the employees were still in the back but thought Mr. Beisley was going to stay down.”

The Training analysis did not question the basis for this reasoning, but should have. Mr. Beisley had shown no willingness to comply with officers’ orders up until that point, and they had no specific reason to believe he was too incapacitated to get up (they describe him as moving around). Nor did Training explore other tactical options the officers might have employed, such as holding Mr. Beisley at gunpoint until backup arrived with additional resources.

The fact that Mr. Beisley did not stay down, but instead got up and continued to threaten the employees in the back of the store certainly highlights the weaknesses of the officers’ decision making, but even if he had stayed down, a thorough Training analysis would have examined this decision making. If Mr. Beisley had been alone in the Starbucks, the decision to back away, seek cover, and employ patience in apprehending him might have been the most prudent course, but the presence of the employees in the storage area significantly changed the risk assessment in a way that should have been addressed by Training and identified as an issue by the Commander and Police Review Board.

The purpose of the Training analysis is not to assess blame, but to aid the Bureau’s training efforts with the acknowledgement (from the Preamble) that “lessons can be drawn from each incident to improve future training and practices.” By ignoring the important question of how the officers here should have weighed the safety of the Starbucks employees in their balancing of various risks, Training missed a critical learning opportunity.

As we have suggested previously and elsewhere in this report, adding tactical decision making as a formal area of review in each of these critical incidents would help to ensure these important issues are not overlooked in future cases.

Subsequent Use of Deadly Force

When Mr. Beisley came out the front door, he again pointed at officers what by all appearances was a real gun. Three officers responded by firing their weapons (a shotgun and two handguns). All three reported awareness of their backdrops, and Officer Lauritzon reported adjusting his positioning to ensure he was firing his shotgun at a downward angle to

avoid having rounds inadvertently traveling into the back area of the store. Training addressed each officer's performance and decision making and concluded the officers' tactics were sound.

One issue not thoroughly addressed by Training was the accuracy of officers' aim. Of the 12 bullets and six shotgun slugs fired, only two struck Mr. Beisley – one inside the store and one when he exited. Officers were all aware of the back drop and the stray bullets were found in the general vicinity. The Training analysis addressed Officer Lauritzon's failure to use his sights when aiming his shotgun, and concluded that created an identifiable risk. With so many missed shots, Training should have considered the need for additional range training for each of these officers. Again, this issue was not addressed by the Commander.

> RECOMMENDATION 8: In officer-involved shootings with significant numbers of missed rounds, the Bureau should consider remedial firearms training for involved officers.

Investigation and Review

All involved officers were interviewed within 48 hours of the shooting. As we have repeatedly noted, this is a significant improvement over prior Bureau practice, but not sufficiently close in time to the event to be considered ideal.

The investigation was thorough, and IA completed its work in 137 days. The Commander's Memorandum, however, offered no additional analysis. It followed the broad contours of the IA findings and concluded all those involved and reviewed had performed in accordance with policy, as recommended by investigators.

This case was closed one week past the 180-day time limit agreed to by the City and the Department of Justice.

January 6, 2019 ◦ Andre Gladen

Officer Consider Vosu responded to a call about a person (later identified as Andre Gladen) sleeping on the front porch of a residence at around 2:00 in the afternoon. The caller reported the person "was acting all psychotic" and he had given him some water but told him he had to leave. He also reported the man was Black and had told the caller he was blind. A second caller – the owner of the property who also lived there – also reported that Mr. Gladen was laying on the porch. Neither caller reported any threatening behavior, but wanted the police to remove Mr. Gladen.

When Officer Vosu assigned himself to the call, dispatch asked whether he wanted a cover officer assigned. He viewed this as a typical call that he could handle himself, and replied that he would advise later whether he needed cover. Officer Vosu arrived at the location and parked directly in front of the house. He first spoke briefly with the owner of the property, then located Mr. Gladen underneath a blanket behind some chairs on the porch. He told Mr. Gladen he needed to leave the property. Mr. Gladen questioned whether Vosu was a real police officer, but also followed Officer Vosu's instruction to stand up. As Mr. Gladen got up, Officer Vosu noticed he wore a wristband that appeared to be from a hospital, a hospital gown, and just one shoe, on the wrong foot.

Mr. Gladen continued to question whether Vosu was a real police officer, and Vosu reported that he was responding to Mr. Gladen in a calm voice, pointing to his badge, and asking whether he was okay and whether he had just come from the hospital. He told Mr. Gladen he didn't want to arrest him, but he just needed to move along someplace else. Officer Vosu stated he could tell Mr. Gladen had an issue with one eye, and acknowledged that the original dispatched call referenced a blind individual, but also stated that it appeared as though Mr. Gladen was tracking his movements with one good eye.

Mr. Gladen then began kicking at the door of the residence with his shod foot. A man (later identified as the original 911 caller) opened the door as Mr. Gladen was kicking it, agitated with Gladen for not having left when he

told him to. The man picked up a large piece of wood (some sort of stick or branch) and threatened Mr. Gladen. Officer Vosu called for “code 1” (non-emergency) cover and told the resident to put the stick down, close the door, and let the police handle it. The resident eventually put the piece of wood down, but did not close the door. Mr. Gladen pushed past him into the residence and the resident quickly followed. Officer Vosu requested “stepped up” cover and then followed the resident into the home.

Inside the home, Officer Vosu saw Mr. Gladen laying on the floor with the resident standing over him, apparently engaged in a struggle. The resident testified to the Grand Jury that Mr. Gladen slipped on the wood floor and fell, ending up on his stomach. The officer attempted to keep Mr. Gladen pinned on the floor and control his arms, knowing or believing that he would have backup officers there very quickly. But Officer Vosu struggled to keep Mr. Gladen down, and tried to enlist the help of the resident. Officer Vosu reported he got no response from the resident and continued to struggle with Mr. Gladen on his own.

Officer Vosu felt like he was losing the struggle, so decided to transition to a different force option. He pushed himself off Mr. Gladen and backed up as he withdrew his Taser. At this point, Officer Vosu was backing into a bedroom, as Mr. Gladen stood up. Officer Vosu gave a warning that he needed to stop or would be tased, and Mr. Gladen stated, “Go ahead and tase me, motherfucker.” Officer Vosu deployed the Taser and Mr. Gladen immediately went down, but only briefly.

As Mr. Gladen went down, Officer Vosu saw a knife in his hand and recognized it as the knife he customarily carried on the outside of his vest. Officer Vosu dropped the Taser and withdrew his firearm. He stepped back as far as he could, but was effectively pinned in the bedroom. He warned Gladen to stop or he would shoot, but Mr. Gladen advanced toward him, with the knife in his hand.

Officer Vosu fired three times, when Mr. Gladen was approximately five feet away from him. Two of the bullets struck Mr. Gladen in the chest, and Mr. Gladen fell to the floor just in front of the officer. The third bullet struck the floor and was deflected into a wall of the residence.

As he stepped over Mr. Gladen, Officer Vosu stated he saw the knife on the ground and, not knowing whether Mr. Gladen had been fully

incapacitated, he picked it up. After he realized that Mr. Gladen no longer posed a threat, he placed the knife back on the ground close to where it had been when he picked it up.

Officer Vosu broadcasted that shots had been fired, then moved to the door of the bedroom and kept his firearm pointed at Mr. Vosu until cover officers arrived about a minute and 40 seconds later. Those officers immediately began providing first aid, which included placing chest seals on the bullet wounds.

The dispatcher requested an emergency medical response as soon as shots fired was broadcast. Paramedics arrived as officers were applying chest seals and took over lifesaving efforts. They transported Mr. Gladen to the hospital, where he later died as a result of the two gunshot wounds to his chest.

The District Attorney presented this case to the Grand Jury, which concluded no criminal charges should be filed against the involved officer. The Police Review Board recommended that the shooting be found in policy, but also recommended a debriefing for Officer Vosu regarding the use of cover officers. The Board further recommended that the Bureau develop guidelines "for knives intended to be used as weapons."

The Chief concurred with the "in policy" findings, but also ordered debriefings for the sergeants on issues related to crime scene management and the importance of public safety statements. Officer Vosu also was required to have a debriefing, but according to the memo from the Commander who conducted it, the only topic of discussion during that conversation was the handling of evidence at crime scenes.

Earlier that day, before 7:00 AM, different officers had been dispatched to two separate calls involving Mr. Gladen. In the first, a woman called to report that Mr. Gladen had threatened her inside her apartment (where she had allowed Mr. Gladen to occasionally stay). Mr. Gladen had left the location by the time the responding officer arrived. About 15 minutes later, dispatch received a welfare check call for a man calling for help from some nearby bushes. The officers linked these two calls, called for a medical response, and assisted paramedics. Mr. Gladen was transported to the hospital by ambulance at that time.

Timeline of Investigation and Review

1/6/2019	Date of Incident
2/21/2019	Grand Jury concluded
6/4/2019	Training Division Review completed
7/26/2019	Internal Affairs Investigation completed
8/13/2019	Commander's Findings completed
9/4/2019	Police Review Board meeting
9/6/2019	Case Closed

OIR Group Analysis

Review of Tactical Decision Making

Officer Vosu said he initially viewed this as a routine call, similar to scores of others he's handled where a resident or business owner calls the police to force someone to move off their property. When asked, "what would be the typical or average response to you showing up and telling the person they need to move along?" he responded, "Close to 100-percent compliance. People leave."[26] This mindset led Officer Vosu to initially decline the suggestion from dispatch that a cover officer be assigned to back him up on this call.

It was only after the resident became engaged with Mr. Gladen that the officer recognized he needed some help, and from there, events spun out so quickly that it was too late for help to arrive.

Police Bureau Training emphasizes the importance of having a cover officer on a call with someone who is perceived to have mental health

[26] Grand Jury Transcript, p. 209.

issues, because it is difficult to predict how subjects with mental illness will react to police contact. The Training analysis described Officer Vosu's decision to decline cover as "generally acceptable but create[d] identifiable risks."

Training was also critical of Officer Vosu's approach to the call, his apparent assumption that it would be simple or routine, and his lack of contingency planning, concluding that his actions were "not consistent with training or create[d] an unnecessary or serious risk."

But these issues identified by Training were not specifically addressed by IA findings or the Commander's review memorandum. Nor were they a formal discussion item for the Police Review Board. In our Fifth Report (February 2018), we recommended:

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

Here, the Investigative Report discussed in great detail various issues relating to post-incident supervision as well as the use of force. This resulted in recommended findings related to each area of review: "Application of Deadly Force;" "Operational Planning and Supervision;" "Post Shooting Procedures;" and "The Use of Physical Force" (related to Taser deployment).

The Commander and Police Review Board followed this same structure laid out by Internal Affairs and made "in policy" findings for each of these areas. The Chief ultimately ordered formal debriefings on issues related to crime scene management, but Officer Vosu had no formal, documented debriefing on issues that had a far greater impact on the outcome of this incident.[27]

[27] Moreover, Officer Vosu's request that the resident assist in subduing Mr. Gladen presented inherent risks to the resident. Many agencies advise that enlisting civilians to become involved in a physical struggle should only be used as a last resort. Yet this request by the officer was not addressed by Training, the Internal Affairs investigation or the Police Review Board.

While it is impossible to say with any certainty how the incident might have been resolved if Officer Vosu had recognized the importance of a cover officer sooner, it is clear that engaging one-on-one with Mr. Gladen was not the safest tactic. Had a cover officer been with Officer Vosu, it could have reduced the likelihood that Mr. Gladen would have been able to make entry into the residence. And in fact, the one-on-one grappling that eventually occurred between the two allowed Mr. Gladen, initially unbeknownst to the officer, to be able to retrieve the officer's knife. It is a well-accepted tenet that tactical decisions meant to keep officers safe reduce the likelihood that those officers will find themselves in a position where they feel deadly force is necessary.

The failure of the Bureau's review process to formally engage with this fundamental fact, despite the express finding of the Training Division, is a gap that should be filled. As we recommended in our Sixth and Seventh Reports, we again reiterate the recommendation made in our Fifth Report (which was reportedly accepted by the Police Bureau), that the Commander and Review Board make express findings related to the tactical decision making leading up to a deadly force incident.

> RECOMMENDATION 9: The Bureau should change its protocols to ensure that tactical decision making that precedes a use of force is a formal area of review in each officer-involved shooting or in-custody death.

Knives as Backup Weapons

At least one member of the Grand Jury and some segments of the Portland community raised questions about the Bureau's regulation of knives carried by officers as backup weapons. The Bureau's investigation and review did not address these questions, either specifically as they came up in this incident or more generally as they related Bureau-wide.

Officer Vosu did not realize that his knife or "dagger" was no longer in its sheath on his vest until he saw Mr. Gladen advancing with the knife in his hand. But neither the investigation nor any level of review addressed the issue of how the dagger was secured, or whether the officer was carrying it in a sufficiently protected location on his vest.

More broadly, the facts of this incident raise questions about the training and policy guidance provided to officers about securing and retaining knives carried as backup weapons. The Police Review Board recommended that the Bureau develop guidelines "for knives intended to be used as weapons." It is not clear what exactly the Board intended and there is no documented evidence that the Bureau accepted and implemented this recommendation in any way. Nonetheless, we learned during our conversations with the Bureau that it has addressed this issue – through in-service training in 2020 and 2021, as well as a Chief's memo and an updated directive that effectively prohibits officers from carrying knives on their external vests.

We recommended in our Sixth Report (January 2019; Recommendation 35) that the Bureau formally address each recommendation made by the Police Review Board, and either accept or reject those recommendations, with a plan for implementation if accepted. Though we acknowledge the Bureau did implement changes to its policies regarding the ways officers carry knives, consistent with the intent of the Review Board, better practice would have been to do so as part of a formal response to its review of this critical incident. We reiterate our prior recommendation here.

> RECOMMENDATION 10: 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.

Inconsistencies between Officer and Witness Statements

On several points, Officer Vosu's testimony and interview statements differed from the involved resident's statements to detectives and grand jury testimony. This is not surprising, as the idea that traumatic stress can have a complex influence on memory and brain function is well-accepted in the scientific community. Nonetheless, better investigative practice would be to acknowledge these discrepancies and attempt to account for them through follow-up questions to Officer Vosu.

- Compliance with Commands: The resident said he put the stick down as soon as Officer Vosu asked him to. Officer Vosu said he had to ask him three times, and the third time was more forceful, when he also told the resident that the subject had a mental health issue.

- Request for Assistance: Officer Vosu stated he asked the resident to help him control Mr. Gladen, but got no response and no assistance. The resident testified to the Grand Jury that he joined the struggle with Mr. Gladen in several ways, attempting to hold his feet and also at one point physically restraining him as he tried to advance on Officer Vosu.

- Back drop: Officer Vosu said his backdrop was clear, and that he was cognizant of the location of the resident at the time he fired. The resident reported that he felt like he was in the line of fire, stating, "after the first pop, if I didn't move an inch and a half to the left, I would not be here right now."[28]

- Crime Scene Integrity: The resident stated that he picked up the knife after the shooting and Officer Vosu directed him to put it back in the location he found it. Officer Vosu did not mention this, nor did anyone ask him about it, despite the fact it was related to the officer's account about his movement of the knife.[29]

Crime Scene Integrity

After having picked up his dagger after the shooting to ensure Mr. Gladen would not be able to retrieve it, Officer Vosu made two decisions that were contrary to Bureau training: (1) returning the dagger to the floor in an attempt to approximate its original position, and (2) not notifying anyone arriving later at the scene of this movement. The training stresses the

[28] Grand Jury Transcript, pp. 95-96. The concerning backdrop issue raised by the civilian witness should also have been addressed during the evaluation of Officer Vosu's use of deadly force incident.

[29] The inconsistencies between the civilian witness and Officer Vosu, could have likely been resolved had the officer been equipped with a body-worn camera; a recording would obviously have provided relevant evidence as to other aspects of the encounter as well. The Bureau remains one of very few of the larger agencies in the country to not outfit its officers with such devices.

importance of notifying detectives if anything is moved at a crime scene. However, Officer Vosu had not yet received Bureau-specific crime scene management training,[30] which previously had been part of the Advanced Academy but was removed when the length of the Academy was reduced from 12 weeks to 10 weeks in 2018 to accommodate an increase in hiring that did not bring a corresponding increase in Training Division instructional staff.

Other crime scene issues presented in this case included mistakes in establishing both the inner and outer perimeters. A crime scene often includes an outer perimeter – a barrier preventing members of the public from wandering in – and an inner perimeter – the most controlled area closest to the location of the incident to which few people other than the investigating detectives and those gathering forensic evidence are permitted to enter. Here, all agreed that the perimeters initially established were too small. The outer perimeter provided neither enough room for all who needed to be at the scene to park their cars and gather, nor enough of a buffer zone around the inner perimeter to protect important evidence.

For example, Officer Vosu's patrol car was set outside the inner perimeter. The location of the vehicle was evidence related to the officer's approach to the scene and initial contact with Mr. Gladen and should have been processed as part of the crime scene. Because of its location, though, other responding officers did not recognize its significance. One officer used the car as a place to escape the weather while maintaining a crime scene log, potentially disturbing evidence inside the vehicle.

The Training analysis recommended that crime scene management training be reincorporated into the Advanced Academy and specifically include lessons on the establishment of crime scenes and moving evidence within a crime scene. The Training Division implemented this recommendation. In 2021, the Advanced Academy was restored to 12 weeks and crime scene management instruction was returned to the curriculum, though we have been informed it may again be reduced to

[30] Crime Scene management was and is taught at the state's Basic Academy and is part of the Field Training Officers' curriculum.

accommodate the recent increase in hiring. While Training should be commended for its independent follow-through, the fact that recommendations from the Training analysis were not formally considered during the Bureau's review process remains a problem that we discuss in greater detail later in this report.

Public Safety Statement

None of the three on-scene supervisors - Sergeants Kile and Slyter and Acting Sergeant Stroh – obtained a public safety statement from Officer Vosu, which left criminal investigators to rely solely on information received from the civilian witness in the early stages of their investigation.

Sergeant Slyter acknowledged he just forgot to obtain the statement; Acting Sergeant Stroh said he believed it was not necessary since the witness had provided the necessary information; Sergeant Kile was not asked about the public safety statement. The Training analysis concluded that the failure to obtain a statement was not consistent with training (but noted that Stroh, as an acting sergeant, had not yet received any training on the issue). Formal documented debriefings were ordered for all three, and Training recommended that the Bureau provide additional instruction regarding the requirement of on-scene supervisors to obtain a public safety statement.

Again, the Training Division addressed this recommendation even though it was not considered during the Bureau's formal review process. Instruction during the 2020 In-Service included an Officer-Involved Shooting Response class that discussed the importance of obtaining public safety statement information. Also, in 2022, the Training Division produced a supervisor checklist which clarified issues related to obtaining the public safety statement.

Investigation and Review

IA interviewed Officer Vosu on January 8, roughly 48 hours after the shooting incident. As we have said repeatedly, this is a significant improvement over prior Bureau practice, but not sufficiently close in time to the event to be considered ideal.

At his request, Officer Vosu was interviewed a second time 10 days later, after he reviewed the transcript from the first interview and wanted to provide additional information. At that second interview, Officer Vosu discussed his removal of the knife from the floor following the shooting.

The case was closed 243 days after the incident, significantly past the 180-day time limit agreed to by the City and the Department of Justice. The delay resulted from a decision to add another formal area of review to the original investigation after the IA investigators had completed their report. This required investigators to interview Officer Vosu a third time, in May 2019, to discuss in further detail his decision to pick up the knife and then return it to the floor and to talk in greater detail about his struggle with Mr. Vosu prior to the officer-involved shooting. The documents show that the Bureau consulted with the City Attorney's office prior to conducting this additional investigation and incurring the delay. We concur that the interest in thoroughness should outweigh the competing interest in meeting the timelines agreed to in the DOJ settlement agreement, and that the unique circumstances of this case (in terms of emerging facts) warranted the extension.

Issues Related to Mental Health Care

Underlying the tragedy of the ultimate outcome of Officer Vosu's interaction with Mr. Gladen is the fact that the day began with a separate police encounter that resulted in Mr. Gladen's short-lived hospital visit. The records from that visit are not part of the officer-involved shooting file.

The City and Bureau's efforts to address longstanding concerns about police interactions with individuals in mental health crisis are part of a well-documented response to the City's 2012 settlement agreement with the U.S. Department of Justice. The work to achieve compliance with the terms of that settlement agreement is ongoing.

But this incident sets up against the backdrop of a larger medical and mental health system that did not work well for Mr. Gladen. Picked up by police at 7:00 AM after his behavior motivated two separate people to call police asking for a welfare check, he was released still wearing a hospital gown and wristband, so that by 2:00 PM he was again behaving in a way that motivated people to call the police, indicating that he continued to need some kind of help. We can't speak in further detail to any specific

systemic shortcomings in this particular case, but the timeline suggests the absence of the type of comprehensive community mental health response that might have provided additional assistance to Mr. Gladen.

April 26, 2019 ◦ Jeb Brock

Three separate 911 calls shortly past 4:00 AM reported a man – identified as Jeb Brock, the cousin and grandson of two of the callers – was inside their home attacking them with a knife and a hammer. On one 911 call, a dispatcher heard an apparent ongoing sexual assault of a female victim, who was screaming that her baby was in the room. Numerous officers and three sergeants all responded.

Officer Michael Gonzalez arrived first, parked a block away, and approached the house on foot. He heard yelling and observed one man on the ground covered in blood. Officers Aaron Rizzo and another officer arrived just after Gonzalez, and the three decided they needed to quickly enter the home to locate and stop the threat, treating the situation as an "active shooter" or "active threat" scenario. Officer Rizzo was carrying his less-lethal shotgun. Sergeant James Mooney arrived and joined the team as officers were entering the house.

As officers made their way through the house, they encountered two additional victims and large amounts of blood in various rooms. (Officers did not stop to help these individuals, citing in interviews their training for dealing with active threats, which emphasizes stopping the threat before assisting victims.) The officers cleared rooms of the house quickly as they made their way eventually to the bedroom where Mr. Brock was assaulting the female victim. Her 16-month old child was in a playpen that had been pushed in front of the door as a barricade.

Officers were able to crack the door open about 12 inches, enough to allow Officer Gonzalez to grab the child and remove her from the area (handing her off to a family member in the next room). Mr. Brock was yelling "I'm going to kill her" while the victim was screaming for help and officers were shouting at him to drop the knife.

Gonzalez returned to the doorway as Officer Rizzo was positioned to fire his less-lethal shotgun through the cracked door. Rizzo's first shot struck Mr. Brock, but did not cause him to release the victim. He fired a second round, which accidentally struck the victim in the midsection.

At that point, Sergeant Mooney forced the door open far enough for him and Officer Gonzalez to enter. Sergeant Mooney – a trained Enhanced Crisis Intervention Team (ECIT) officer – said he realized they needed to take a different approach and consciously modified his tone, from yelling commands to speaking calmly and trying to communicate with Mr. Brock. He said things like, "You don't have to do this, you don't have to hurt her, we'll get through this." (Officer Gonzalez remarked during his IA interview on Sergeant Mooney's calm voice.) The other officers stopped shouting commands, and Sergeant Mooney became the single point of contact with Mr. Brock.

Mr. Brock was laying on the bed, holding the victim in front of him with his arm around her neck and shoulders. He held an eight-inch kitchen knife in his other hand, pointing it at her throat and sometimes moving it down her body to point at her stomach. She was struggling with Mr. Brock, grabbing at the knife and attempting to push his arm away from her. Both Gonzalez and Mooney articulated their fear for the victim's life and their belief that deadly force was the only remaining option while also recognizing that Mr. Brock's use of the victim as a shield made taking a shot difficult and risky.

Officer Gonzalez said he saw the victim move down as she pushed on Brock's arm and recognized he had a shot, so raised his gun and fired once at the subject's head. Sergeant Mooney had also been waiting for a shot. He saw the victim move away from Brock immediately after Gonzalez fired and fired one shot at Mr. Brock's torso. Both shots struck Mr. Brock, incapacitating him. The officers quickly moved the victim from the room and secured the knife. It was obvious to the officers that Mr. Brock was deceased.

The officer involved shooting occurred 11 minutes after the initial 911 call.

Two other responding sergeants took command of various aspects of the post-shooting response, with one assuming the role of Incident Commander. Medical teams had already been dispatched to assist victims. One was sent to assess Mr. Brock. He was pronounced dead at the scene within minutes of the shooting.

The District Attorney's Office presented the case to the Grand Jury. On June 3, 2019, the Grand Jury returned a "Not True Bill" with respect to the officers' use of deadly force.

The Police Review Board met in November 2019 and determined all officers' and supervisors' actions were within policy in all areas reviewed. The Board made no other recommendations. The Chief concurred with the Board's findings.

Timeline of Investigation and Review

4/29/2019	Date of Incident
6/3/2019	Grand Jury concluded
9/13/2019	Training Division Review completed
9/19/2019	Internal Affairs Investigation completed
10/4/2019	Commander's Findings completed
11/1/2019	Police Review Board meeting
11/7/2019	Case Closed

OIR Group Analysis

Officers responded quickly and decisively to this event. The 911 callers described a dynamic scene, multiple people with stab wounds, and an ongoing sexual assault.

The Training analysis meticulously evaluated this incident in a 33-page report, thoroughly analyzing officers' decision making at various points. The first critical decision was officers' assessment of the scenario and the conclusion that this was an active threat scenario for which staging, waiting for resources, and gathering numerous officers to follow a coordinated plan was not warranted.

As they arrived on scene and saw one victim bleeding on the sidewalk and heard from dispatch about other victims inside the house, Gonzalez,

Rizzo, and Mooney all appropriately came to the conclusion that the situation met the definition of an "Active Threat" provided in PPB training materials: "An armed person(s) who has used deadly physical force on another person and continues to do so while having unrestricted access to additional victims." This determination shaped officers' response at each step, as the training doctrine for an active shooter/active threat scenario differs from the expectations for a response to a more static situation.

Training also analyzed in detail other aspects of the response for consistency with PPB training:

- Officer Gonzalez's decision to approach the residence alone despite the risks and contradictory instructions from a supervisor;
- The lack of planning and communication prior to entering and beginning to clear the house;
- Officers' decision to bypass victims and focus on neutralizing the threat;
- The decision to immediately address Mr. Brock rather than notifying SERT as would be expected in a less dynamic scenario;
- The decision to deploy the less-lethal shotgun;
- Officer Gonzalez's use of deadly force; and
- Sergeant Mooney's use of deadly force, seconds after Gonzalez's single shot.

After scrutiny of the officers' interview statements and evaluation of Training Division curricula, the Training analysis concluded that officers' actions demonstrated sound and effective tactics on each point. We found the Training Division Review to be thorough and well-reasoned.

Among this issues the Training analysis addressed were questions about the use of the less-lethal shotgun. While lethal force would have been justified by the threat Mr. Brock presented, Officer Rizzo (with the concurrence of Sergeant Mooney) decided to use less lethal to minimize the risk to the victim. The officers hoped to gain compliance from Mr. Brock as a result of the pain inflicted by the projectile. The small opening in the door did not allow for the cleanest of shots, which is why officers

decided to try less lethal rounds, taking the calculated risk that the rounds may strike the victim. That the second round did in fact hit the victim was unfortunate, but a risk officers were aware of and believed they needed to accept.

The Training Division Review also focused on the supervisory response. Sergeant Mooney arrived at the location just as officers were preparing to enter the residence, and subsequently joined the team clearing the house. He did not assume command, but described himself as being in a supervisory role while also being part of the team. The officers were not certain when Sergeant Mooney joined them in the house, but seemed to continue moving in the same direction, with Sergeant Mooney acting as an effective member of the team. During their IA interviews, officers expressed some confusion about whether the sergeant assumed command when he joined the entry team, but there was no apparent confusion in their approach and any uncertainty about who was in charge did not impact officers' response.

In many prior cases we've reviewed, we have been critical of sergeants who insert themselves into tactical roles in situations where it would have been preferable for them to delegate the role to available officers while maintaining supervisory perspective on the incident. We have repeatedly recommended that the Bureau address this issue through training and accountability measures. Cognizant of that, the lieutenant assigned to complete the Training analysis specifically requested IA investigators to ask the sergeant about his thought process when deciding to join the team.

Sergeant Mooney explained that his thought process centered on the exigency of the situation and the resources available. He noted they didn't have time to wait for others to arrive because they believed there was an active assailant in the house who was continuing to stab people.

Training questioned whether Sergeant Mooney's direct involvement was based on the nature of the incident or whether he had needlessly interjected himself into the situation. The analysis looked at three factors to conclude it was appropriate for Sergeant Mooney join the entry team:

- The event was dynamic and the sergeant reasonably believed that containing Mr. Brock was the most pressing need.

- The contact team needed additional resources.
- Sergeant Mooney knew from radio communications that two other sergeants were en route and could assume a supervisory role outside the house.

In a dynamic situation with an active threat, the Training analysis determined it is consistent with training for a sergeant to fold into a team that was moving to engage the threat. We appreciate the Training Division's detailed assessment of this issue, and understand the important differences between this scenario and others where we've been critical of sergeant's tactical roles.

With respect to the entire incident, Training noted some aspects of officers' response that were not perfect – officers ideally might have taken a moment to communicate a plan and to acknowledge Sergeant Mooney's role, for example. Nonetheless, the Training analysis ultimately concluded officers' performance was both consistent with Bureau training on active threat scenarios and admirable for its speed and coordination. We do not disagree with this assessment.

Training Division Recommendations

This incident was a low probability, high risk event for which it is often difficult for a law enforcement agency to adequately train its officers. The Training Division used its review of this incident to recommend continued and ongoing training on active threat/shooter responses, to specifically encompass:

- How to differentiate between traditional critical incidents and active threat situations;
- Improved communication between responding officers and sergeants on planning an immediate response; and
- Additional training for sergeants on specific skills needed to effectively respond to active threats, including guidance on how and when to adopt various roles.

Training also recommended an evaluation of the effectiveness of its current 40mm less-lethal weapon system, and clarity around the policy on public safety statements.[31]

In this case, the Training Division Captain prepared a memo to the Commander of the Professional Standards Division – dated a little more than a month after the case was closed – detailing Training's efforts to implement each of these recommendations. We have not routinely seen these memos in other cases. And while we again commend the Bureau for following through on the Training Division recommendations, as we have noted elsewhere and discuss more fully below, these recommendations should have been formally considered by the Review Board and the Chief.

Timeliness of Investigation and Review

The involved officers were interviewed by IA investigators the day after this incident. As we have commented repeatedly, even this delay is still not consistent with best investigative practices. The investigation was thorough and was completed within 144 days. This case was closed in 193 days, over the 180-day time limit agreed to by the City and the Department of Justice.

The Commander's Memorandum was a short and simple concurrence with the "in policy" findings proposed by IA that was completed in two weeks.

[31] The Incident Commander here did not specifically interview officers related to information needed for the public safety statement because he had obtained the necessary information from other sources. This recommendation seeks clarity around the policy requirements for officer interviews.

June 9, 2019 ◦ David Downs

Officers responded to a call for service regarding a disturbance in a stairwell that came in on a Sunday morning. The reporting party had gone to his multi-story office building and parked on the fifth floor. Approaching the elevator, he heard the sounds of conflict from the stairway below him. In his 911 call, he said that he had not seen anyone directly, but that he had yelled down that he was contacting the police. A male subject had replied that he was possibly armed with a knife and a bomb, and that he had a hostage. This man was later identified as David Downs, a 39-year-old white male. The reporting party heard a female calling for help, and he passed along this information to the call-taker.

A group of six officers arrived at the scene within minutes. The last to arrive brought out a less lethal 40mm launcher. They came together for planning purposes, and they were assisted by the reporting party in gaining access to the building. Officer Cassandra Wells took the lead role in formulating a plan, which included having one officer stay in the lobby in case the subject emerged from the stairwell.

Five officers then took an elevator up to the 9th floor and then looked down the stairwell at Mr. Downs, whom they could see was positioned a few floors down from their current position. The officers discussed their respective roles, which included communication, less lethal cover, and lethal cover. As they got closer by descending the stairs, they realized Mr. Downs was accompanied by a woman; this person was naked from the waist down, apparently bleeding, and later described as “whimpering.” Officers determined she was there against her will.

Moving even closer, they saw that Mr. Downs was holding a knife. At this point, they were approximately one and a half floors (or three sets of stairs) above Downs. Officer Wells, who was pre-designated as the lead communicator with the subject, gave Downs multiple commands to drop the knife, and warned that force would be used if he did not comply. Downs did not, and instead responded by saying “Shoot me.” He also brandished a pen-like object that he claimed was a detonator.

At that point the designated “less lethal” officer (Jackson Oldham) fired a total of four 40mm “foam ball” projectiles at Mr. Downs in slow succession (given that he needed to re-load after each use). This use of force did not seem to affect him. Officer Oldham shifted position after the second round, based on another officer’s speculation that the rounds were hitting a railing rather than the subject. Though Officer Oldham thought at least one of the final two rounds had struck Downs, it did not gain his compliance. On the contrary, Downs yelled back at them to shoot him, and again brandished the pen-like object he claimed was a bomb.

It was at that point that Mr. Downs grabbed the woman and pulled her in front of himself, still holding the knife and pointing it at the woman’s torso and neck areas. The officers agreed that further attempts with the less lethal launcher would not be advisable, since available target areas on Downs’s body had become limited and the encounter had risen in intensity into an endangered hostage situation.

Officers engaged in further efforts at communication with Mr. Downs in a last attempt to de-escalate the situation. These only seemed to further antagonize Downs, who was screaming back at them. Meanwhile, Officer Wells and Officer Nathan Kirby-Glatkowski were positioned next to each other and armed with their duty weapons. They were discussing which of them had the better opportunity to shoot without harming the hostage, who had lowered herself into a position so that Mr. Downs’s head was now available as a target. Kirby-Glatkowski said he would take the shot. He introduced himself in one last effort to establish some type of positive communication with Downs.[32] Then he fired one round that struck Mr. Downs in the forehead and fatally injured him.[33]

This allowed the female hostage to run out of the area to safety. Officers responded to assist her and to evaluate Mr. Downs, whose head wound was clearly fatal. They decided against following the normal protocol of handcuffing him in light of the obvious severity of his injuries. Fewer than

[32] He later told Internal Affairs investigators that he had used that approach successfully in an earlier call for service on the same shift.

[33] There was subsequent confusion in the criminal reports regarding references to a second shot having been fired, but this discrepancy was reviewed and appears to have been the function of misunderstanding.

five minutes had passed between the officers' entry into the building and the firing of the fatal shot.

During a subsequent interview with criminal investigators, the female victim explained that she had met Mr. Downs earlier that day at the bus station, and that their intention in walking to the nearby grocery store and then entering the stairwell was to use drugs together. She said that they did not ultimately do that, though she was aware that Downs had used methamphetamine at some point.[34] She said they were engaging in consensual sexual activity in the stairwell, but that he had become irrationally angry at some point and accused her of stealing from him. At one point, he had punched her several times and refused to let her leave the area. She also confirmed that Downs, whom she described as having been "fighting" with the "people" above them[35], was holding a knife at her throat when the shot was fired.

Supervisors responded promptly to the scene, with one acting sergeant arriving before its conclusion (but too late to access the building and actively supervise). Two other sergeants (including one acting) were also efficient in responding, and they collaborated with each other in making sure the proper investigative protocols were initiated.

When an acting Captain joined them, he quickly pieced together the need for an additional area of response: namely a safety evacuation of the scene and an assessment by the Explosive Devices Unit to ensure that the object Mr. Downs had claimed to be a bomb was not a threat. (It was not.)

The District Attorney's Office presented the case to the Grand Jury. On August 16, 2019, the Grand Jury returned a "Not True Bill" with respect to the use of deadly force.

The Police Review Board met in March of 2020 and determined all officers' and supervisors' actions were within policy in all areas reviewed. This was in keeping with the "in-policy" recommendations that had been reached by Internal Affairs and the relevant Commander. The Board made

[34] This, and the presence of other drugs, was confirmed in the toxicology report.

[35] She seemed confused and agitated at times during the interview, a dynamic that the detectives handled with reasonable care.

no other recommendations. The Chief concurred with the Board's findings.

Timeline of Investigation and Review

6/9/2019	Date of Incident
8/2/2019	Internal Affairs Investigation completed
8/16/2019	Grand Jury completed
1/20/2020	Training Division Review completed
2/20/2019	Commander's Findings completed
3/19/2020	Police Review Board meeting
3/20/2020	Case Closed

OIR Group Analysis

Per protocol, the Training Division evaluated the performance of Officer Oldham (less lethal), Officer Kirby-Glatkowski, and the responding supervisors (initial scene response and post-shooting procedures).

The Training Division memo isolated the incident into its different phases. They were as follows:

- Information gathering prior to contact
- Various aspects of the initial contact, including threat assessment, development of strategy, consideration of options and policy requirements, and contingency planning
- Officer Oldham's deployment of the 40mm launcher
- Officer Kirby-Glatkowski's use of deadly force

- The officers' post-shooting response
- The initial supervisory response
- The subsequent supervision of crime scene and investigation.

In each of the separate elements they delineated, the actions were found by Training to have demonstrated "sound and effective tactics." And in each instance, offered specific details in support of their contentions.

The precipitating events that caused Mr. Downs's lapse into aggression toward the female victim and his seemingly intentional provocation of law enforcement are not clear. For whatever reason they occurred, though, they prompted a 911 call from an uninvolved witness and appeared to justify the exigency with which the officers collectively reacted. And there were notable efforts at planning and coordination that subsequently occurred, in spite of the compressed time frame.

These included the officers' initial gathering at the scene, their enlisting of an officer with a less lethal weapon as part of their response group, a decision to leave one officer in the lobby in case the subject emerged from the stairwell, and a division of responsibilities among the five officers who ascended to the top floor of the building with the intent of giving themselves space to assess the situation as they located the subject and began to move down the stairs.

Once they had spotted Mr. Downs, they moved from attempts at communication to giving commands, to use of a less lethal force option, and finally to their shift toward preparing for deadly force in response to his re-positioning of the female victim and the direct threat posed by the knife he was visibly holding. Even then, their planning and coordination continued.

One officer took the access card and left the stairwell in case more officers were ultimately needed. And the two officers with their weapons drawn – and who were positioned shoulder to shoulder – spoke with each other with the idea that only one should fire so as to minimize the threat of accidentally harming the victim. They eventually agreed that Officer Kirby-Glatkowski would take the shot – but not before he made one last effort to engage Downs in a de-escalation technique by saying his own name and asking Downs about his. He was also appropriately conscious of the woman's position: it was only after noticing her head slide down several

inches that he believed he had a clear and relatively safe target line. He fired one round from twenty feet away that struck and killed Mr. Downs.

In short, the officers accomplished several noteworthy things in a compressed time period. The subject's angry rejection of their commands, his clearly armed status, his threats, the ineffectiveness of less lethal options, and the proximity of the female victim, all legitimately supported their ultimate belief that a deadly force situation had arisen. In fact, the blood that was seemingly visible on the victim raised concerns that she had already been harmed. Their tactics were sound and consistent with PPB training and expectations, as confirmed by the Training Division analysis of the incident.

One interesting example was that Officer Oldham refrained from issuing a warning prior to firing his less lethal rounds, in a deviation from policy guidelines. But he had done so consciously, after requesting that Officer Wells do so (as the designated point of communication with the subject) and with the knowledge that the subject's own vocalizations and the echoes from the stairwell made it prudent to limit the number of voices.[36]

The collective response to the issue of the "detonator" and potential bomb that was threatened by Mr. Downs was slow to materialize in the immediate aftermath of the case. The extent to which the officers took that particular threat seriously is not entirely clear, and there is not a reference to their incorporating it into their immediate efforts to address the scene after the shooting. Still, addressing the possibility was an important step that was initially missed by the first supervisors to respond. It was to the credit of the acting captain that the Explosive Devices Unit was finally summoned to ensure that no threat remained.

In its own discussion of the supervisory response the Training Division cited the inexperience of the three sergeants. This was perhaps partially in mitigation of this oversight. But it was also partially to reinforce their collective inclination to collaborate in ensuring that the different

[36] It is not clear from the record that Officer Wells specifically did so. (Officer Oldham professed to be unsure.) This is an issue that Training should have pursued or noted; however, at an earlier point in the interactions with Mr. Downs (and close in time to the less-lethal deployment), she had warned him that force would be used, and he had responded defiantly.

requirements of a critical incident response were being met – a task that they largely succeeded in accomplishing.

There were no recommendations in the Training Division analysis.

The actions of the individual supervisors were similarly found to be “in-policy” by the Police Review Board after the Internal Affairs review. Unfortunately, no direct mention of the “detonator” issue had made its way into the analysis more overtly.

We also are confused as to the lengthy gap between the finalization of the Internal Affairs investigation and the latter stages of the review process, which did not conclude until some nine months after the incident itself. The reasons for the delay are not clear from the record, though we note that the 284-day duration significantly exceeded the “180 day” deadline established by the USDOJ agreement.

July 30, 2019 ◦ Lane Martin

A security guard at a beauty salon called 911 on a weekday afternoon after encountering a man who was taking property from the back of a parked jeep and behaving erratically. The man, later identified as Lane Martin, was holding a small axe and a knife and was claiming to be a federal agent. The reporting party stayed on the line and described Martin moving aggressively toward him with the knife before putting it in his right front pocket and leaving the scene.

Numerous officers began to respond from different directions. They made visual contact with Mr. Martin at different times and began to coordinate their actions. Martin, a 31-year-old white male was located at an intersection with considerable vehicle and pedestrian traffic, and was behaving erratically. One officer requested the deployment of an Enhanced Crisis Intervention Team Officer to the scene, and a team member who had just started his shift quickly assigned himself to the call (though was one of the later people to arrive).

Within moments, an initial group of four officers gathered about 30 feet from Mr. Martin, who was described as yelling and waving his arms. The attempts to establish communication with him were unsuccessful. The officers divided roles: one had a Taser, one had a 40 mm less lethal launcher, and two were providing lethal cover with their firearms. Upon noticing what appeared to be an axe in Martin's beltline, the officers began to give commands and to issue warnings about force deployment. Martin responded by taking hold of the axe.

At this point, one officer put out radio traffic requesting additional backup. The officer with the less lethal launcher considered using it, but refrained because of uncertainty about the backdrop. The officers estimated they were 15 feet away from Mr. Martin at this point. Martin backed away, still holding the axe, and then began to walk away from the officers, occasionally swinging the axe and accosting a driver in a stopped vehicle.

The patrol response quickly multiplied, and soon there were as many as 10 Bureau officers trailing Mr. Martin on foot as he walked away from

them. Some had armed themselves with less lethal 40 mm launchers. Martin continued to yell irrationally, and continued to ignore police commands. At one point he approached a transit stop and bystanders cleared out of his way as additional radio cars reached the intersection.

Two of the responding officers with 40 mm less lethal weapons – Officer Nicholas Bianchini and Acting Sergeant David Kemple – began communicating with each other about the potential need to fire at Mr. Martin out of concern for the danger he was potentially posing to the surrounding members of the public. This became more refined in their minds as he approached a corner with a busy convenience store.

Multiple commands and references to force had not been effective. Accordingly, Officer Bianchini called out a warning to the other officers (to ensure they were not confused about what was happening) and fired one 40 mm soft tip projectile at the back of Martin's legs as he continued to walk away. The round struck Mr. Martin, and he responded by jumping, running a brief distance, and – significantly – dropping the axe.

Acting Sergeant Kemple observed this and continued to monitor Mr. Martin as he reached another intersection and began to motion toward his waistband. Kemple was concerned that he was reaching for another weapon, and was intent on getting Martin to stop his efforts to move away from officers. He fired a single less lethal round toward Martin's legs in response.

This round also struck Martin, who at this point turned and ran from the pursuing officers. They trailed him around a corner, on foot and in patrol cars, and saw that he had entered an apartment complex. They located him again in a walkway between apartment buildings in the complex.

He was near a stairway, and could potentially have continued away from the officers in a couple of directions. Instead, he turned and confronted them as they quickly gathered in a grouping of seven that filled the space between buildings. They were equipped in various ways (Taser, less-lethal, firearm), including one officer with an AR-15 rifle and one with a shield.

Among them was Officer Gary Doran, who held his duty weapon. He had been part of the group trailing Mr. Martin on foot for some time, had witnessed the unsuccessful efforts at gaining compliance through

commands and use of the less-lethal munitions, and had developed an impression of him as extremely angry and aggressive. As he and the other officers faced off with Martin from approximately 20 feet away, within seconds he noted Martin motioning with his hands in an effort to extract something from his pants pocket.

He gave orders for Martin to get on the ground and then saw him remove from a pocket what he perceived to be a knife. Out of concern that Mr. Martin presented a deadly threat to his partners, he fired 11 rounds and struck Martin with 9 of them. Approximately 30 seconds had passed between the time Mr. Martin had entered the breezeway ahead of the officers and the use of deadly force.[37]

Officers made a tactical approach at that point and worked to render medical aid on Mr. Martin for several minutes before medical personnel arrived. He was pronounced dead at the scene. A folding knife was located near where Mr. Martin had fallen.[38]

The District Attorney's Office presented the case to the Grand Jury. On October 14, 2019, the Grand Jury returned a "No True Bill" with respect to the officer's use of deadly force.

The Internal Affairs investigation focused on multiple PPB members in keeping with normal protocol. They included Officer Doran (for his use of deadly force), Officer Bianchini and acting Sergeant Kemple for their respective uses of less lethal force, and four supervisors for their managerial responses to the scene after the shots had been fired. Internal Affairs recommended that the actions of each be found in policy. The Commanders' Review concurred with this assessment, with no additional recommendations. The Police Review Board and the Chief also reviewed the case and concurred with the findings that all reviewed members had acted in compliance with PPB policy. The case was closed on April 2, 2020.

The Training Division's review of the incident addressed its different stages individually. It covered the information gathering prior to the first

[37] The entirety of the police engagement, from first officer contact to the shots being fired, was approximately nine minutes.

[38] This was moved by one of the officers on scene, a deviation from normal protocols that was assessed in the subsequent administrative review.

officers' making contact (and as the event proceeded), the initial contacts with Mr. Martin and the weighing of options by officers at each phase of the encounter, the respective force deployments (including deadly force), the supervision during and after the encounter, and several aspects of the post-incident response.

Timeline of Investigation and Review

7/30/2019	Date of Incident
10/14/2019	Grand Jury Completed
2/5/20	Internal Affairs Investigation completed
3/3/2020	Training Division Review completed
3/3/2020	Commander's Findings completed
4/1/2020	Police Review Board meeting
4/2/2020	Case Closed

OIR Group Analysis

Training Memo Format

The Training Division memo is methodical in many places, and identifies a number of issues that it addresses thoughtfully. It also correctly acknowledges that decision-making about compliance with policy is outside its bailiwick and instead the role of the Bureau's different participants in the formal review process. Instead, at the outset of the memo it mentions that what Training does instead is apply a "rating scale" to each critical decision as to the extent to which it is consistent with "sound and effective tactics."

We have seen this done with clarity and effectiveness in the Division's analyses of other critical incidents, including some of the ones featured in this Report. However, the memo does not overtly state its findings with regard to each of the identified key moments in the encounter. Although much can be gleaned from the conclusory language in the memo and the substance of the analysis itself, and while useful recommendations arise from the concerns that the evaluation thoughtfully raises, a straightforward statement of the individual ratings would have been welcome and consistent with practice.

> RECOMMENDATION 11: The Training Division should articulate its specific findings with regard to Bureau members' various critical decisions and performance in each phase of a critical incident.

Training Findings and Recommendations

The encounter had several stages and involved several different Bureau members, who had arrived in staggered fashion in response to the radio traffic about the unfolding event. As the Training analysis observed, the first officers communicated well with each other and with dispatch. Their effective responses included waiting for a cover officer before engaging, broadcasting their respective positions in relation to Mr. Martin, promptly making a 40 mm less lethal weapon available, watching him from a distance rather than approaching in light of his behavior, attempting to engage him in conversation (without success), and the summoning of additional resources. This included an officer from the Bureau's Enhanced Crisis Intervention Team ("ECIT"), in recognition of the fact that Mr. Martin was experiencing a mental health emergency of some sort.

In Training's view, the officers were obligated to engage with Mr. Martin in light of the conduct that had prompted the 911 call and their own observations, and did so in accordance with their training.

Various attempts to communicate with Mr. Martin did not produce responses other than agitated yelling and screaming that officers considered unintelligible. When he turned and began walking in a southerly direction away from them, Officer Bianchini and Acting Sergeant Kemple (both armed with 40 mm launchers) communicated with each other about their concern that he would enter a nearby convenience store.

They each gave warnings before they deployed one round each with an interval between the shots. After Bianchini's round (which he believed struck Martin in the leg), Mr. Martin dropped the axe for the last time[39], but did not comply with other commands or stop moving. Acting Sergeant Kemple fired his 40 mm round in response to what he believed was Mr. Martin reaching for his waistband for another weapon; he too believed he had struck Martin with his round, and the autopsy appeared to confirm this.

From there, Mr. Martin began running away from the officers, trailed by several Bureau members on foot and at least two radio cars. A group of officers followed Martin into the ground level breezeway of an apartment complex, where he turned and faced the grouping of officers who had assembled. Four of them established themselves in a line facing Martin, two armed with handguns (including Officer Doran), Acting Sergeant Kemple with his 40 mm launcher, and another with a Taser. They were quickly joined by three other officers, armed respectively with AR 15 rifle, a handgun, and a shield.

The shooting occurred within seconds, as Mr. Martin turned to face the officers with what they variously described as a confrontational and aggressive demeanor. Disengaging was not considered an option in light of the overall context of Martin's actions and elevated state, and the presumed danger to any residents of the complex.

Officer Doran was aware that Martin had been seen with a knife earlier in the encounter, and noted Martin digging into his pants pocket with his right hand. When he removed what Doran perceived to be knife, Doran yelled for Martin to get on the ground and said he fired multiple rounds from 15 to 20 feet away in defense of his partners, whom he believed Mr. Martin was going to attack.

Officer Doran's state of mind, based on impressions about Martin's actions that were corroborated by witness officers, was central to the Internal Affairs recommendation that his use of deadly force be found consistent

[39] Per the accounts of the officers, Mr. Martin had set the axe down and promptly picked it up again at one point prior to the deployment of the less lethal munitions.

with policy. The Training Division discussion of this portion of the incident tracked that analysis without additional comment.

The Training memo then engaged in several pages of analysis as to the medical aid, crime scene integrity, and supervisorial management of various post-shooting protocols. The involved Bureau members were found to have acted in a manner largely consistent with training.

Training did, however, offer three recommendations that emerged from its review of the incident. They were as follows:

- ***Development of a one-day training class for Acting Sergeants:*** This recommendation was prompted by two factors. The first was the recent prevalence of Acting Sergeants within PPB as a response to staffing needs, and a recognition that additional preparation for them was warranted. The second was specific to the case, and involved Acting Sergeant Kemple's decision to engage as a 40 mm operator (who ultimately used force) when he arrived at the scene, rather than restricting himself to a supervisorial role. (The other sergeants who ultimately responded each arrived in the shooting's immediate aftermath.) Training made a point of acknowledging Kemple's extremely limited experience in his new position. But the memo also stated that it would have been preferable for Kemple to focus on supervising (starting with announcing his status over the radio as he approached the scene) and to delegate to another available officer trained in the 40 mm.

- ***Reinforcement of protocol for Public Safety Statements***: The "public safety statement" is the brief set of facts that officers involved in a deadly force incident are required to share with responding supervisors; the idea is to provide that information that is necessary to ensure that the situation is stable and allow for immediate safety needs to be met.[40] In this incident, Officer Doran was ordered to give the statement, and did. However, the Training memo pointed out that the preference is to obtain the statement from a witness officer if applicable – as it would have been here.

[40] This is in balance with the involved officer's rights as the now subject of various investigative processes, and the statement is therefore limited in scope.

- ***Clarification for Internal Affairs regarding the "21-foot rule":*** The "21-foot Rule" is a long-established principle that warns officers of the threat posed by a person with an edged weapon at that distance or closer, given the space they could travel before effective reaction could occur. In recent years, it has been re-characterized as an overly simplistic approach to a concept that is more nuanced and circumstance-dependent. Training has updated its approach to the concept by referring instead to the "Reactionary Gap," a more generalized way of characterizing officers' need to account for the brief but significant time lag between a subject's actions and the officer's ability to perceive and respond to it. The Training memo noted that an Internal Affairs investigator made reference to the 21-foot rule in a follow-up question to Officer Doran about his familiarity with the dangers posed by edged weapons. Though it did not seem to have been prominent in Doran's thinking or in the ultimate decision to use deadly force, Training still saw the investigator's reference as an indication that reinforcement about the updated thinking on this concept was warranted.

The Training Division memo also addressed the issue of Mr. Martin's knife being moved a few feet away from his body by a responding officer in the immediate aftermath of the shooting. This occurred in the seconds after the shooting, as officers moved in to establish custody and render medical aid. The intent was to ensure that the injured subject could not reach it. The officer acknowledged doing so to a supervisor, and Training found that the action did not deviate from proper handling of evidence in that context.

Rounds Fired and Other Officers' Perceptions

As detailed above, Officer Doran fired 11 rounds at Mr. Martin. While that sheer number of rounds is not inherently inordinate, it is more rounds that is usually evident in our review of officer-involved shootings. Office Doran was questioned about this during his Internal Affairs interview, and said that he continued firing until he could see a "change in behavior" that indicated the shots were having an effect. He said that this did not happen right away – to the point where he was surprised and not even sure the subject had been struck. He added that when did finally notice a

change in the subject's "motor functioning" as he focused on his hands, he stopped firing.

Asked about this technique (as opposed to stopping to reassess after an initial one or more rounds), Office Doran explained that this was consistent with training he had recently received: to fire "Quickly, repeatedly until you get a response." This issue was not further explored in the Internal Affairs analysis (though references to other relevant training, and copies of lesson plans, were included in the investigative report).[41] Nor was the specific issue analyzed by the Training Division in its relatively concise endorsement of Officer Doran's actions.

A second concern related to Officer Doran's status as the only officer who fired at that climactic moment. To be clear, the statements of witness officers matched Doran's overall perceptions and described the subject's behavior in comparable ways. But the other officer with a firearm in the "front group" that was facing the subject did not see him emerge with something specific in his hands as he was "digging" in his waistband area; this officer did not fire even though his weapon was pointed. Another adjacent officer had a rifle as lethal cover; he too was focused on the subject's hands, saw tugging, was preparing to fire if necessary, and then heard the shots from Officer Doran's gun.

Both officers were asked whether they considered the use of deadly force to have been appropriate, and both confirmed their view that it was. (The rifle officer had told the Grand Jury that "for all intents and purposes," he himself was intending to fire when Doran's actions preempted him). However, their distinctive perceptions and decision-making were noteworthy, and warranted analysis that was not overtly pursued in either the Internal Affairs or Training Division reports. Ideally, it would have been.

[41] While PPB officers had apparently gone through a recent drill in firearms training that tested officers in firing multiple rounds in a close span of time, the stated "goal" was 6 accurate rounds in 4 seconds, and continuous firing was not a feature of the plan.

RECOMMENDATION 12: During its investigation and review of any deadly force incident, the firing of multiple rounds should be overtly and independently analyzed as an issue for both the underlying investigation and the Training Division review.

RECOMMENDATION 13: Whenever a situation presents itself where one officer decides to use deadly force and other on-scene officers do not, the Bureau should fully inquire about this dichotomy during its investigation and review.

Exploring Additional Options

In this incident, Bureau members were confronted with the task of attempting to safely apprehend a man with multiple edged weapons whose state of mental agitation precluded effective communication – and apparently cooperation or compliance. The protracted nature of the overall encounter, in combination with its fatal outcome, naturally raises questions about the existence of available less lethal alternatives as a means of increasing tactical options and promoting a different result.

Here, the Internal Affairs case memo makes an interesting observation in this regard. The author describes "long range" pepper sprays or gels that could reach a distance of approximately 35 feet and provide another force option for scenarios such as this. He recommends that the agency pursue this product as a possible enhancement of officer equipment.

There is no other indication in the record of this idea receiving further consideration; nor does the Training Division memo delve into a survey of other possible approaches for future reference. While responsive "brainstorming" and the development of new approaches may well have occurred, the Bureau's existing multi-layer review process would be an effective structure to identify and promote follow-through of any such innovations.

RECOMMENDATION 14: Where applicable, the Bureau should use the critical incident review process as infrastructure for the identification and development of potential innovative solutions to the circumstances that arise in individual cases and may have future pertinence.

Mental Health Intervention Effort

Mr. Martin's erratic behavior and his irrational statements to Bureau personnel were themselves indicative of a mental health episode; subsequent investigation established that he had a treatment history and had multiple contacts with mental health clinicians in the weeks preceding his death. Unfortunately, officers' attempts to accommodate this reality in the moment were limited in terms of time and effectiveness.

Mr. Martin's possession of multiple weapons, his ignoring or defiance of different requests and commands, and his movement away from the officers for an uncertain purpose all complicated the ability to establish a rapport and de-escalate the situation. When the ECIT officer arrived at the scene, he saw Mr. Martin waving the axe. He later described Martin's demeanor to investigators as "amped up" and perhaps under the influence of drugs. He said Martin was yelling unintelligibly and alternating between waving the axe and holding out papers. Meanwhile, nearby officers were asking him to drop the axe.

Attempting to speak ("as ECIT") to Martin from what he estimated was a distance of 30 feet, the officer was unable to develop any sort of dialogue (and professed to be concerned about the possibility of Martin's throwing the axe in their direction). He soon joined the other officers in an apprehension capacity and was arriving at the apartment complex to assist when the shots were fired.

The effort at de-escalation by a specially trained officer was commendably recognized as applicable to the situation and attempted within the confines of challenging circumstances. The combination of Mr. Martin's agitated state and the threat he posed to officers (and bystanders) by virtue of his weapons was an obvious and perhaps insurmountable obstacle in terms of what could be achieved. Still, given the prominence of mental health concerns in law enforcement's critical incidents, it would have been interesting to have this aspect of the response analyzed more deeply as part of the Training memo and overall review. While the Internal Affairs interview with the officer explored his efforts, it was not formally discussed or addressed.

RECOMMENDATION 15: The Training Division should incorporate an analysis of ECIT efforts into its assessment of critical incidents where it is relevant to the facts of the case.

Timeliness of Investigation and Review

This case took 247 days to complete. The IA investigation itself was not completed until 190 days past the incident; the process seems to have moved along expeditiously after that. Both timeframes were out of compliance with the requirements of the USDOJ settlement agreement.

The case file chronology indicates that the majority of the administrative investigation was completed by early September of 2019 – some five weeks after the incident. But there was a prolonged (and unexplained) delay subsequent to that. Then, around the time of the new year and five months after the incident, additional supervisors were added as "reviewed members"; their interviews were the final steps in compiling the investigative package.

Common Themes and Issues

Portland's Investigation and Review Process

We have been observing and commenting on Portland's processes for investigating and reviewing critical incidents for over a decade. Our reports have generally been laudatory – though we often make recommendations for ways we think things might be improved, we also talk about aspects of the process we have found to be exceptional and the myriad ways the Bureau has been ahead of other comparable law enforcement agencies.

The Bureau's processes still have many commendable features – with few exceptions, Detectives and Internal Affairs investigators conduct professional, thorough investigations, the Training Division Reviews detail and document officer performance and decision-making in ways we don't generally see in many other agencies, and the Police Review Board is structured to be inclusive of diverse perspectives. Unfortunately, despite these features, our recent analyses have often left us frustrated by the failure of the review process to address some basic concerns.

In our Seventh Report, we discussed these issues at length and made recommendations related to the formal consideration of pre-incident tactical decision making, the use of Commanders' Memoranda as a meaningful analytic tool, and consideration of the Training Division Reviews to inform other aspects of the review process. All of the cases reviewed in this report pre-date the publication of that last report. So without belaboring those points further, we raise them again here in the context of this latest collection of incidents, to demonstrate their ongoing relevance.

Examining Tactical Issues

Internal Affairs investigations into officer-involved shootings define various "Areas of Review" that include "Application of Deadly Force," "Operational Planning and Supervision," and "Post Shooting Procedures." Where applicable, there are additional areas of review relating to the use of non-deadly force (such as the K-9 or less-lethal shotgun). While tactical issues are sometimes addressed as related to "Operational Planning," what we have found lacking is a systematic look at the tactical decision-making that preceded and may have led to the use of force. Because the reviewing Commander, the Police Review Board and, ultimately, the Chief and Police Commissioner follow the IA rubric of "Areas of Review," no formal findings regarding tactics are considered.

Given the recent nationwide focus (and the corresponding demands of the Portland community) on promoting efforts at de-escalation as a way for law enforcement to reduce the need to use force, including deadly force, it is incumbent upon the Bureau to evaluate those efforts and formally assess responding officers' performance in this arena. The extent to which officers employed available de-escalation techniques could and should be folded into a distinct formal finding of whether pre-event tactics met Bureau policy and training standards.

In the cases we reviewed here, that type of systematic look at tactical decision making would have more effectively addressed these issues:

- The communications breakdowns surrounding the shooting of Mr. Rice, including efforts to communicate with Mr. Rice's girlfriend that were apparently not relayed to the shooting officer.
- Officers' decision to exit the coffee shop after their initial encounter with Mr. Beisley without detaining or securing him or his weapon.
- The shooting officer's lack of contingency planning and decision to engage with Mr. Gladen without backup.

Commanders' Reviews and Findings

The Bureau's review process requires the Responsibility Unit Manager in the shooting officers' chain of command (typically at the rank of

Commander) to review the Internal Affairs investigation and recommended findings and prepare a memo indicating whether or not they concur with the investigator's recommended findings. In the past, we have been impressed with the quality (if not always the timeliness) of the Commander's memoranda – they were often expansive in their scope and breadth of analysis, and demonstrated a willingness to be critical of officers' performance while offering constructive solutions in the form of training or other remedial measures.

In the current group of cases, though, as with some of those we reviewed in our Seventh Report, six of the eight Commanders' memos we reviewed here contain little analysis and are simply boiler-plate concurrences with the investigator's recommended findings. They added little value to the review process, yet in some cases apparently delayed the Police Review Board proceedings. For example, in the incident involving Mr. Rice, three months passed between completion of the IA investigation and the Commander's Memorandum.

As we recommended in our last report, we would prefer to see Commander's Memoranda that are more than cursory reviews and instead contain an analysis of the facts of each case as they relate to Bureau training, policy, and expectations, as we often saw in past cases. But considering the difficulty the Bureau has had in keeping to the timeliness standards agreed to in the USDOJ settlement agreement, if the Commander's Memorandum is only going to be a blanket concurrence with investigator's recommendations, the Bureau should consider eliminating this step. At a minimum, the Bureau should consider streamlining the process by scheduling the Review Board meetings as soon as the IA investigation is complete, with the expectation that Commanders will produce their memos prior to that hearing and can provide further input at the Review Board meeting.

> RECOMMENDATION 16: The Bureau should consider returning to the requirement that Commanders produce memoranda that substantively address all areas of review in officer-involved shooting investigations or, at a minimum, should streamline the review process by not delaying Police Review Board meetings to allow for production of Commander's Memoranda.

Training Division Reviews

The Training Division (with a few noted exceptions) prepares comprehensive memos detailing their thorough and candid analyses of officer-involved shootings and other critical incidents. The reviews track the decision-making of officers and supervisors point-by-point through an incident and assess whether the performance was consistent with training over a four-point rating scale.[42] The stated goal is to draw lessons from each incident "to improve future training and practices."

Beyond its rating of each decision point, Training sometimes makes recommendations relating to broader training concerns or performance issues. Unfortunately, the Bureau's review process has no formal mechanism or protocol for considering these recommendations, and the opportunity for improving future outcomes is sometimes lost.

For example, a recommendation made by Training in its analysis of the case involving Mr. Hansen has not been addressed by the Bureau. Professional Standards has no record of its implementation, and the K-9 unit (to whom the recommendation was directed) has no record of this recommendation being considered.

Conversely, in the case involving Mr. Gladen, the Training analysis made recommendations regarding the need for additional training on crime scene management and public safety statements. While none of the recommendations was formally considered or adopted by other players in the review system (Commander, Police Review Board, or Chief), Training to its credit implemented the recommendations within its next training cycle.

Likewise, in the Brock case, the Training analysis identified a need for additional training on specific topics related to active threat scenarios, and then proactively implemented those recommendations and documented their completion – just a little more than a month after the case was closed – in a memo to the Commander of the Professional Standards Division.

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

The distinction between these cases seems to be related to who would be responsible for implementing a particular recommendation – when the Training Division recommended new or additional training, it took ownership of the recommendation and implemented it without specific orders emanating from the Bureau's review process. When the Training recommendation applied to a different entity within the Bureau (K-9, as in the Hansen case), no one followed through.

This observation is not meant to criticize the K-9 unit – which as far as we know never even learned about the recommendation from Training – but it does highlight the importance of our prior recommendation (Sixth Report, Recommendation 34) regarding the need to formalize the consideration and assignment of any recommended reforms. Unless they are officially channeled up the chain of command, vetted, and (where appropriate) assigned to a specific unit or individual for completion, thoughtful recommendations made by the Training Division are too often ignored or forgotten.

> RECOMMENDATION 17: The Bureau should develop protocols to ensure that any recommendations made by the Training Division in its review of an officer-involved shooting or other critical incident be considered by both the Police Review Board and the Chief.

Implementation and Follow-Through

During the course of our decade-plus engagement in Portland, we have made more than 200 recommendations on a range of topics. Many of these we have made multiple times, in different contexts. And frequently when we have presented our reports to City Council, a Commissioner or member of the public asks whether we have tracked the implementation of any prior recommendations. Because the scope of our work with the Bureau has been limited to reviewing particular officer-involved shootings and in-custody deaths, the answer is generally "no," unless the same circumstance has been presented in subsequent critical incidents. This has frequently been the case, as for example with our repeated emphasis on the role of sergeants and their propensity for engaging tactically in circumstances where it would be preferable for them to maintain a supervisory presence.

Other recommendations related to the Bureau's internal review processes have also been repeated from report to report, as in this report, where we again emphasize the importance of requiring formal review of pre-incident tactics and engaging in a meaningful way with recommendations made by Training.

To be sure, many of our recommendations have been embraced and implemented in impactful ways. For example, the Bureau now approaches and provides medical assistance to subjects in deadly force incidents much more quickly than was routine practice when we first began reviewing cases in Portland. Similarly, the Bureau has changed its approach to what was once considered "doctrine" – the so-called "21-foot rule" – to the point that the Training Division questioned the use of the term by an Internal Affairs investigator in the case involving Mr. Martin. And all references to "suicide by cop" have been eliminated from the Bureau's review process, consistent with a recommendation we made in 2016. We also saw a couple of examples in the cases covered in this report where Training explicitly and thoughtfully addressed the issue of on-scene sergeants who assigned themselves to tactical roles, questioning whether there were officers to whom they could have delegated those tasks.

Nonetheless, after years of reviewing critical incidents involving PPB members, we find ourselves repeating recommendations to a disconcerting extent, despite the fact that the Bureau almost always professes to agree with the need for reform. This may be due in part to the frequent turnover in the Chief's office, and the fact that a successor Chief may not even be aware of a predecessor's stated commitment to adopt certain recommendations.

We have learned through years of experience with multiple agencies that unless recommendations are assigned to a specific individual or office, with a due date and mechanism for reporting back on completion, they too often fall through the cracks. We therefore make an overarching recommendation to the City relating to our prior and current reports.

RECOMMENDATION 18: The City should assign an individual to review all prior recommendations made by OIR Group in their reviews of officer-involved shootings, uses of deadly force, and in-custody deaths, to assess those recommendations for current relevance, and to report on the Bureau's response to each recommendation and progress toward implementation.

Timeliness of Review Process

The Bureau's agreement with the United States Department of Justice requires it to complete the investigative and review process of officer-involved shootings within 180 days. It didn't meet that deadline in any of the eight cases we reviewed here, with some approaching or exceeding 100 days past that deadline.

The table below shows all the incidents we have reviewed since the Bureau's agreement with the Justice Department to complete its investigation and review process within 180 days. The shaded rows are the cases covered in this report.

There was no single apparent phase of review that repeatedly caused delays. In one case (Harris), a long delay was attributed in part to the uncertainty about how it should be classified. Another delay (in Gladen) resulted from a decision to add another formal area of review to the original investigation after the IA investigators had completed their report. But unlike in prior reports, where we saw some analysis of why a case was late and why, we generally saw little explanation for the blown deadlines in this set of cases.

As we have recommended in the past (Seventh Report, Recommendation 28) the Bureau should ensure that it identifies the cause of the delay and evaluates any potential fixes in any case that extends beyond the 180-day deadline.

Timing to Completion of Investigation and Review

Subject's Name	Date of Incident	Time to Case Closure (days)
Lane Martin	7/30/2019	247
David Downs	6/9/2019	284
Jeb Brock	4/26/2019	193
Andre Gladen	1/6/2019	243
Ryan Beisley	12/7/2018	188
Richard Barry	11/22/2018	175
Jason Hansen	10/19/2018	274
Samuel Rice	10/10/2018	262
Patrick Kimmons	9/30/2018	166
Jonathan Harris	8/31/2018	257
John Elifritz	4/7/2018	250
Sarah Brown	3/8/2018	252
Chase Peeples	10/27/17	239
Jesse Brockner	8/30/2017	342
Michael Grubbe	5/28/2017	242
Terrell Johnson	5/10/2017	237
Don Perkins	2/9/2017	151
Quanice Hayes	2/9/2017	155
Steven Liffel	12/5/2016	185
Timothy Bucher	5/24/2016	155
Michael Johnson	11/6/2015	173
David Ellis	7/5/2015	138
Alan Bellew	6/28/2015	158
Michael Harrison	5/17/2015	155
Christopher Healy	3/22/2015	149
Ryan Sudlow	2/17/2015	321
Denoris McClendon	9/1/2014	189

Recommendations

1: The Bureau's holistic review of any critical incident should identify and address issues relating to officers' language and overall professionalism.

2: PPB should work to gather statements from known witnesses to critical incidents, or should clearly document any unsuccessful efforts at doing so.

3: The Bureau should review its rules of engagement for supervisors and officers to address situations in which equipment limitations prevent officers from communicating with incident command, specifically to set guidelines governing how communication limitations impact officers' authority to take independent action and use deadly force.

4: In an officer-involved shooting investigation, when there is reference to an earlier incident involving the same parties, reports and other information relating to that earlier event should be collected and included in the investigative file and discussed as part of the overall analysis.

5: The Bureau's K-9 unit should review its procedures for how officers notify others of their status and location, as recommended by the Training Division.

6: The Bureau should revise its protocols to ensure that investigators endeavor to collect facts relating to all aspects of a deadly force event, including post incident challenges, even if the performance involves a law enforcement officer from an outside agency.

7: The Bureau should modify its protocols to require investigators to both photograph injuries and collect medical records in cases where individuals are injured but not killed in officer-involved shootings, or to document the reasons for their inability to do so.

8: In officer-involved shootings with significant numbers of missed rounds, the Bureau should consider remedial firearms training for involved officers.

9: The Bureau should change its protocols to ensure that tactical decision making that precedes a use of force is a formal area of review in each officer-involved shooting or in-custody death.

10: 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.

11: The Training Division should articulate its specific findings with regard to Bureau members' various critical decisions and performance in each phase of a critical incident.

12: During its investigation and review of any deadly force incident, the firing of multiple rounds should be overtly and independently analyzed as an issue for both the underlying investigation and the Training Division review.

13: Whenever a situation presents itself where one officer decides to use deadly force and other on-scene officers do not, the Bureau should fully inquire about this dichotomy during its investigation and review.

14: Where applicable, the Bureau should use the critical incident review process as infrastructure for the identification and development of potential innovative solutions to the circumstances that arise in individual cases and may have future pertinence.

15: The Training Division should incorporate an analysis of ECIT efforts into its assessment of critical incidents where it is relevant to the facts of the case.

16: The Bureau should consider returning to the requirement that Commanders produce memoranda that substantively address all areas of review in officer-involved shooting investigations or, at a minimum, should streamline the review process by not delaying Police Review Board meetings to allow for production of Commander's Memoranda.

17: The Bureau should develop protocols to ensure that any recommendations made by the Training Division in its review of an officer-involved shooting or other critical incident be considered by both the Police Review Board and the Chief.

18: The City should assign an individual to review all prior recommendations made by OIR Group in their reviews of officer-involved shootings, uses of deadly force, and in-custody deaths, to assess those recommendations for current relevance, and to report on the Bureau's response to each and progress toward implementation.

Table of Critical Incidents Reviewed by OIR Group

2004 – 2019

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

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?
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
Keaton Otis	5/12/10	2	19-21	9mm	Hit	Fatal	Handgun	African-American	Yes	No
Craig Boehler	11/23/10	1	3	AR-15	Hit	Fatal[f]	Handgun and rifle	White	No	No
Darrryll Ferguson	12/17/10	2	20	9mm	Hit	Fatal	Replica handgun/ BB gun	White	No	No
Marcus Lagozzino	12/27/10	1	4	AR-15	Hit	Non-fatal	Machete	White	Yes	No
Kevin Moffett	1/1/11	1	1	9mm	Non-hit	Non-fatal	Handgun	African-American	No	No
Thomas Higginbotham	1/2/11	2	12	9mm	Hit	Fatal	Knife	White	Yes	No
Ralph Turner	3/6/11	2	4-5; then cover fire	9mm; AR-15	Non-hit	Non-fatal	Rifle, shotgun, and handgun	White	Yes	No
William Kyle Monroe	6/30/11	1	4	Less-lethal shotgun loaded with lethal rounds	Hit	Non-fatal	None	White	Yes	Yes
Darris Johnson	7/9/11	3	N/A	N/A	N/A	In-custody death	N/A	African-American	No	No
Brad Lee Morgan	1/25/12	2	5	9mm	Hit	Fatal	Replica handgun	White	Yes	No

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?
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
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

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

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?
Jonathan Harris	8/31/18	1	N/A	N/A	N/A	Non-fatal use of deadly force	Handgun	African-American	No	No
Patrick Kimmons	9/30/18	2	16	9mm	Hit	Fatal	Handgun	African-American	No	No
Samuel Rice	10/10/18	1	1	AR-15	Hit	Fatal	Knife	White	Yes	No
Jason Hansen	10/19/18	1	3	9mm	Hit	Non-fatal	Handgun	White	No	No
Richard Barry	11/22/18	2	N/A	N/A	N/A	In-custody death	N/A	White	Yes	No
Ryan Beisley	12/7/18	4	18	9mm; shotgun	Hit	Non-fatal	Replica handgun/ BB gun	White	Yes	No
Andre Gladen	1/6/19	1	3	9mm	Hit	Fatal	Knife	African-American	Yes	No
Jeb Brock	4/26/19	2	2	9mm	Hit	Fatal	Knife	White	Yes	No
David Downs	6/9/19	1	1	9mm	Hit	Fatal	Knife	White	No	No
Lane Martin	7/30/19	1	11	9mm	Hit	Fatal	Knife	White	Yes	No

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

---------Reviewed in OIR Group's Report on Portland Police Bureau Officer-Involved Shootings, Sixth Report, January 2019
---------Reviewed in OIR Group's Report on Portland Police Bureau Officer-Involved Shootings, Seventh Report, April 2020
---------Reviewed in OIR Group's Report on Portland Police Bureau Officer-Involved Shootings, Eighth Report, November 2022

[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.