Independent Review of Hillsboro Police Department: Use of Force, Policies, and Accountability Systems

August 2021

OIR GROUP

Michael Gennaco

Robert Miller

Samara Marion

OIR
GROUP

323-821-0586

7142 Trask Avenue | Playa del Rey, CA 90293

OIRGroup.com

Table of Contents

Introduction

In March of this year, the Chief of Police of the Hillsboro Police Department (HPD) engaged OIR Group[1] to perform an independent review of a broad range of issues and systems within the Hillsboro Police Department. These include how the agency investigates officer-involved shootings and other uses of force, addresses officer misconduct and public complaints, and could best develop a meaningful force review board. We also explored the Police Department's response to civil lawsuits brought against the Department as well as its practices relating to officer discipline, remedial training and mental health crisis calls. The report below is the result of that process. It covers our independent assessment of Department performance – not only in terms of how HPD operates in the field, but also of the effectiveness with which its internal review of those actions helps to enhance future performance.

HPD has many internal review systems that reflect a commitment to continual improvement and reform. At the same time, there are important arenas where the Department could benefit from a more rigorous, comprehensive approach.

A good example is the Department's handling of officer-involved shootings. Pursuant to state law, HPD necessarily relies on the Washington County interagency Major Crimes Team (MCT) to conduct the criminal investigation of any officer-involved shooting involving its personnel. This protocol helps ensure an important element of independence as the legality of the incident is assessed. But it still falls to the involved agency to address the important issues of *administrative* accountability and systemic review. HPD currently waits for completion of the criminal investigation before initiating its own internal review – a delay that is detrimental for reasons we discuss below. Accordingly, we recommend that HPD enhance its approach to officer-involved shootings by immediately initiating an administrative investigation that includes prompt interviews of involved and witness officers.

More broadly, the Department's administrative review of officer-involved shootings, other critical incidents (such as deaths in custody), and other significant uses of force would be significantly strengthened by creating a standing Force Review Board. As we explain, we advocate a "holistic approach" that addresses multiple elements of these

[1] OIR Group is a team that specializes in police practices and the independent civilian oversight of law enforcement. Its work with police agencies throughout California, Oregon and in several other states includes investigations, monitoring and systems evaluation.

key events, including decision-making, tactics, supervision, training, equipment and the agency's post-incident response.

We also consider at length the manner in which HPD evaluates more common uses of force that occur in the field. Based on that evaluation, we suggest ways in which the Department could maximize the value it derives from the assessments by frontline supervisors as well as the more formal investigations of its Office of Professional Standards.

We review HPD's internal affairs procedures and take a detailed look at several completed misconduct investigations and the accountability decisions made by Department leadership – not for their own sake but as vehicles for assessing the strengths and limitations of the current process.

Finally, we consider the procedures that HPD employs to respond to complaints from members of the public as well as to claims and lawsuits against the Department. We view litigation as a "complaint with a price tag attached" and discuss the importance of identifying individual misconduct as well as systemic issues that create risk to the Department and the City. We offer strategies to ensure that robust identification and remediation occur during that process.

Throughout this report, we offer recommendations that are responsive to our findings and, importantly, are readily achievable as well as potentially beneficial. They offer practical suggestions for how the HPD might develop or revise policies and practices and reduce impediments to improved performance, robust community relations, and transparency – all worthy goals that are especially resonant in light of contemporary expectations.[2] Notably, our understanding is that this independent review was initiated by HPD's own leadership. This in itself is an encouraging sign, and evidence of a genuine commitment to meaningful scrutiny and positive change. For all the importance of outside accountability, police agencies themselves remain uniquely situated in their control of and responsibility for their own effectiveness. We hope the contents of this report, with its emphasis on stronger internal review systems going forward, will be a mechanism for HPD to heighten that effectiveness on behalf of the Hillsboro community.

[2] All recommendations are also listed numerically in an Appendix.

Methodology

Hillsboro Police Department is comprised of 198 employees, including 143 sworn officers and 55 professional staff. It serves a community of over 100,000 in the greater Portland area. We reviewed the Department's policy manual as well as directives and policy discussions from HPD leadership. We spoke with ten individuals within the Department who had specialized knowledge relevant to our assessment areas. We reviewed 65 use of force incident files from 2018-2020, including body-worn camera footage where it existed. We reviewed 17 internal affairs investigations and four investigations of community member complaints.

We are grateful to the leadership and professional staff of the HPD for facilitating those steps, particularly in light of the constraints imposed by Covid 19. Our numerous requests for information and scheduling assistance were met with a swift, flexible and complete response. We appreciate the cooperation and expertise of the HPD staff we encountered; beyond making our review feasible, HPD's personnel made it better than it otherwise would have been.

Section One: Critical Incident Review Systems

The legal authority to arrest and use force in doing so – including deadly force – under certain prescribed circumstances is an awesome and unique authority afforded law enforcement. Not coincidentally, it is also the aspect of policing that generates the greatest amount of controversy and a significant portion of its civil liability issues.

A fundamental question in any officer-involved shooting is whether the force was justified as "objectively reasonable" and proportionate under the totality of the circumstances. Law enforcement has a core responsibility to address incidents of excessive or unjustified force through individual accountability measures – up to and including referral for criminal charges. Importantly, though, a truly effective review process sees this key issue as a starting point in what ultimately becomes a more comprehensive inquiry.

Ideally, an agency reviews its use of force deployment in a larger context of policy, training, planning, tactics, equipment, supervision, decision-making, and de-escalation. In doing this, the agency recognizes that a use of force could be both legally justified and "in policy," while still falling short of the better, realistically attainable outcome that a different approach might have produced. For the sake of both officer and public safety,

the best processes will treat each incident as a potential learning opportunity for the entire agency as well as the involved officers.

Our review of HPD's force incidents was informed by this philosophy. Our intent in reviewing HPD's investigative files was not to re-assess the findings in each case but rather to suggest improvements to the Department's evaluation of incidents. Most force incidents we evaluated were well documented and thoughtfully reviewed. Nonetheless, we sometimes found a reluctance to decisively address problematic conduct. We therefore suggest specific ways that HPD should "widen the lens" of its scrutiny to enhance existing force review of individual officer performance and larger systemic issues.

Officer-Involved Shootings

When an HPD officer shoots and kills or injures someone in the course of police duties, the Department immediately notifies the multi-agency Major Crimes Team to conduct the criminal investigation. This is pursuant to a memorandum of understanding (MOU) to which all the law enforcement agencies in Washington County are signatories. The MOU specifies that "officer involved applications of deadly physical force" are a Major Crimes Team (MCT) "required response." The MCT team is comprised of investigators, supervisors, public information officers from the non-involved agency and the District Attorney. Initially, HPD officers assist in managing the crime scene, preserving evidence and identifying witnesses until the MCT team arrives and takes over the criminal investigation. HPD participation during the crime scene walk through is limited to HPD's involved and witness officers serving as a guide to the MCT team.

HPD may assist MCT in administrative tasks such as coordinating the scheduling of officer interviews but in general does not receive any information from MCT concerning the criminal investigation until its conclusion. HPD does not monitor MCT's criminal interviews of HPD's involved and witness officers.

Upon completion of its criminal investigation, the MCT submits its results to the Washington County District Attorney's Office. The District Attorney's Office reviews the involved officers' actions to determine whether the use of deadly force constituted a violation of law. MCT provides a briefing to HPD command staff at the conclusion of MCT's criminal investigation.

While the criminal aspect of any deadly force incident is a vital component of police accountability and often draws public attention, the prosecution of officers for their use of deadly force is extremely rare. This is a function of many factors, among them the

historical deference given to those who are professionally obligated to use force under certain circumstances, and the importance of the relevant legal standard – which emphasizes the involved officers' "state of mind" regarding threat perception. While this may be changing through adjustments to standards of conduct as well as evolving public expectations, it is still true that the narrow focus in the criminal arena gives added weight to the importance of rigorous administrative review.

A police agency's administrative investigation – sometimes called a professional standards or internal affairs investigation – aims to determine whether the agency's policies were violated, not whether criminal laws were broken. The administrative investigation plays a significant role in setting standards and expectations for accountability, lessons learned and impact on future operations. Additionally, the administrative investigation and assessment of the deadly force incidents are within the agency's control and not dependent on the District Attorney's timeline and decision.

Our review of HPD's officer-involved shooting files focused on the administrative processes. We found areas for improvement in HPD's approach, beginning with its exclusive reliance on the county Major Crimes Team's criminal investigation fact-gathering as the basis for the administrative assessment.

The MCT's criminal investigation is narrow and focuses on determining whether the use of deadly force constituted a crime. Criminal detectives generally do not interview individuals or gather evidence with a goal of determining whether the officer's conduct violated policy (although these concepts can have considerable overlap). They do not assess pre-deadly force decision-making, review supervisors' actions or consider post-incident conduct such as providing medical care in a timely manner.

Agencies need a thorough, timely and effective administrative review process that enables identification of officer conduct and operational issues that fall below the agency's expectations and standards. Additionally, it is imperative that the administrative review process delineate each of the internal reviewers' roles, including the identification, development and implementation of action plans that address individual officer performance as well as broader systemic issues. In reviewing one of HPD's officer-involved shootings, we examined whether the Department used investigation, analysis, review, accountability and remediation to advance the overarching goals of improving performance and reducing future deadly force incidents. Here, we found missed opportunities.

The factual background of the case is as follows:

> An HPD officer was exiting the police station when he encountered an individual speaking in limited English who said he was afraid of a man

standing a few feet behind him who had inexplicably followed him for several miles in his car. After motioning to the reporting victim to move to the side of the building, the officer attempted to engage verbally with the other man (hereinafter subject) and then observed that he was holding a black handgun under his armpit. The officer informed dispatch that he had a suspect with a gun, activated his body-worn camera and pulled his service weapon out and held it behind his leg. The officer blocked the subject as he moved in the direction of the victim, using his left hand to grab hold of the subject while also grabbing hold of the subject with his service weapon in his right hand, sometimes holding the weapon against the subject's back and head. He told the subject several times to drop the gun. The subject did not respond, but walked slowly forward. For several seconds, the officer continued grabbing onto the subject with both hands and redirecting the subject's movement. At one point, the officer successfully turned the subject in the opposite direction from where the victim was standing. When the officer appeared to release or disengage from the subject, the subject continued moving forward, the officer placed both his hands on his service weapon, told the subject to "drop the gun" several times and then shot the subject twice in the back as the subject moved to the corner of a parked vehicle. The subject fell and rolled onto his back, and a black pistol and bullets landed to the left of him. The officer picked up the pistol and put it in his back pocket.

A backup officer arrived just as the shooting occurred. The involved officer instructed this officer to take care of the victim who was standing by the building. Another officer handcuffed the victim. The involved officer and first back up officer rolled the subject onto his stomach, observed a large circle of blood on his sweatshirt, and then handcuffed him. The subject was making guttural sounds but was nonresponsive to the officers' questions about his identity. The subject died at the scene.

Pursuant to the aforementioned protocol, MCT conducted the criminal investigation of the officer-involved shooting and forwarded their file to the Washington County District Attorney. The DA then conducted a review and concluded the shooting was legally justified.

"After Action Report": Strengths and Limitations

Upon the conclusion of the criminal investigation, members of HPD's Training Division wrote a detailed After Action Report (AAR)[3] as part of HPD's administrative review of the shooting. The After Action Report provided the District Attorney's summary of the shooting, highlighted aspects of the officer's statement from his criminal investigative interview, summarized the officer's body-worn camera footage and discussed physiological factors that may have influenced the incident. The AAR concluded the officer-involved shooting was in policy. It found that the officer's decision to draw his service pistol and still go "hands on" with the subject was "very intuitive, timely and a proportionate force response" and that the officer responded as another hypothetical well-trained officer facing the same or similar circumstances would act.

The AAR acknowledged what it described as "safety features" when going hands on with a subject while holding a service weapon. The AAR discussed the increased possibility of an unintentional discharge caused by intermuscular cross-over (the gun hand involuntarily duplicating the non-gun hand's movements) and an involuntary clutching reflex when exerting physical control while simultaneously holding a service weapon. The report concluded that the officer did not have any better alternatives to resolve this incident but stated the Training Division would make officers aware of the potential dangers of physically struggling with a suspect while handling an unholstered weapon and stress the importance of keeping the service weapon holstered while going hands on. The AAR also recommended that the Department invest in "chipping" officers' handguns so that their body-worn cameras activate anytime the handgun is drawn.

Initiated in 2018, HPD's current practice of requiring its Training Division to conduct an AAR review of its officer-involved shootings is a positive step. The AAR in this OIS reflected careful review of the MCT's criminal investigation, the officer's body-worn camera footage and the officer's MCT interview. It highlighted the officer's quick-thinking

---

[3] Policy Manual 302 specifies circumstances requiring an After-Action Report:

- Injuries to a suspect requiring medical transport
- Higher levels of force employed (i.e., less lethal, impact weapon, focused blows, Taser, OC spray, running tackle, firearms, K9 contact, force used while in restraints - except de-minimis force).
- The incident contains unique circumstances, such as when the person upon whom force was used is a child under the age of 18, an elderly person, a person with mental illness, or other person with significant medical or mental conditions.
- The suspect is alleging excessive force at the scene or shortly thereafter. Any subsequent citizen complaints of excessive force or bias shall be forwarded to the Office of Professional Standards for investigation.

responses, such as radioing dispatch and activating his BWC as soon as he realized he was dealing with an armed suspect. It also acknowledged the backup officer's calm composure and vital role in initial on-scene investigative procedures. The AAR also discussed the risks of an unintentional discharge when going hands on with a subject while holding a service weapon.

Nonetheless, the scope of HPD's review was problematic for several reasons. While the AAR noted the risks of an unintentional discharge, it did not consider how the officer's ability to effectively go "hands on" with the subject was compromised by holding his service weapon at the same time. Apart from its conclusion that a hypothetically well-trained officer would have done the same thing, the AAR analysis did not consider the implications of the officer's choice to engage in a physical struggle while holding his weapon in one hand – which inevitably limited his ability to effectively control the subject and protect himself and the victim. Nor did the AAR address the risk of the subject accessing the officer's unholstered weapon. Additionally, by attempting to hold onto the subject's back with both hands, the officer's view of the subject's gun hand was obscured at best. These topics merited discussion.

Additionally, the AAR review focused largely on the moment deadly force was used and overlooked post-incident issues that were worthy of consideration. For example:

- Although they called for emergency medical assistance after the shooting, none of the on-scene officers transitioned to monitoring the subject while waiting for emergency medical assistance to arrive, as required by HPD's policy. The shooting and backup officers rolled the subject on his stomach, observed a large circle of blood on his sweatshirt, and then handcuffed him. They made no attempt to check for a pulse, monitor his breathing, or staunch his bleeding. When the Fire Department crew arrived on scene to provide medical assistance, HPD officers did not brief them about the subject's injuries. Instead, a Fire Department member had to ask the on-scene sergeant if he was the point of contact and if so, what could he tell them about the subject's injuries.

HPD's Post-Force Response Process and Reporting policy requires officers using force to obtain medical assistance for the subject, monitor the subject while awaiting medical assistance, and notify medical personnel that the person was subjected to force including the description of the force used and circumstances relevant to assessing potential medical risks to the subject. Although the officers promptly requested medical assistance, they did not monitor the subject while awaiting medical assistance and did not brief the medical emergency crew when they arrived. These medical considerations were worthy of evaluation.

To HPD's credit, the Department has recently updated its Use of Force Policy to require officers to provide immediate lifesaving measures to individuals subjected to force if the officer is in a position to do so and has been trained. In light of HPD's new policy on providing immediate lifesaving measures and our observations in the aforementioned case, we recommend the Department provide training to address officer and supervisor duties when force has been used on a subject, to include requesting medical assistance, providing life-saving measures, monitoring the subject, and notifying medical assistance as to the force used and the circumstance.

- Following the shooting, HPD officers handcuffed the victim even though the victim had initiated the encounter with HPD for his own protection after driving to the station for that purpose, explained his concerns about the subject in a way that the officer corroborated through his observations at the scene, and been endangered to the point of forming the officer's rationale for shooting the subject. Neither the lawfulness nor impact of handcuffing the victim was ever evaluated during this incident review.

- The shooting officer used his bare hands to pick up the subject's gun and place it in his back pocket. He then provided it to the on-duty sergeant who received it with his bare hands. Issues concerning crime-scene preservation should always be part of any officer- involved shooting review.

Potential Enhancements to the HPD Process

1) Administrative Investigation from the Outset

The Department should initiate an administrative investigation of the incident during the immediate aftermath of an officer-involved shooting. Many agencies routinely assign this responsibility to internal affairs personnel as part of the initial notifications and response. This enables HPD's personnel to immediately begin coordinating with the criminal investigators to learn as much as they can about the incident early on. Administrative investigators would participate in the walk-through of the scene and observe interviews of witness and involved officers. This early access to information about the incident gives the agency the ability to focus immediately on relevant concerns about policy, tactics, supervision or communications that need not (nor should not) wait until the conclusion of the investigation.

Currently HPD's policy provides for an administrative review "if determined necessary," but requires that it be commenced after completion of the criminal investigation.[4] This approach raises a couple of concerns. Apart from impeding the effectiveness of a potential investigation through delayed familiarity and issue-spotting, it overlooks the notion that a robust administrative review should be automatic and not subject to a case-specific determination of need. Our view is that deadly force events are inherently worthy of critical review and thoughtful assessment, even in cases when the officers have performed in keeping with policy (or even exceptionally).

2) Timely Interview of Involved and Witness Officers

It is true that the standardized practice of assigning the criminal investigation of a Hillsboro officer-involved shooting to representatives from outside agencies offsets *some* of the inherent concerns about objectivity and rigor. But the MCT's investigative protocol is not flawless in this regard. The timeliness of officers' interviews is one problematic feature that merits attention.

In the above-mentioned OIS, the involved and witness officers were not interviewed for two days. Prompt interviews of involved and witness officers, prior to personnel going off duty, is an investigative best practice. It promotes the purest recollection of events, maintains the integrity of the investigation and enhances the public's confidence in the process.[5] Memory experts have recognized the advantage of obtaining recollection promptly and have disavowed those who have advocated for delay.[6] Moreover, such delays are contrary to normal investigative protocols involving on-scene interviews of, for instance, armed robbery victims. Special procedures for officers involved in shootings fuel the perception among many in the community that "police investigating police" provide their colleagues with advantageous treatment not extended to members of the public.

3) Need for Video-taped Interviews

---

[4] HPD's Officer Employee Involved Traumatic Incident Policy states that "[i]f determined necessary by the Chief of Police, a separate Internal Affairs Investigation will be conducted pursuant to Hillsboro Police Department Policy 601 and 1310 and in compliance with the HPOA Collective Bargaining Agreement after the criminal investigation has been completed."

[5] We recognize that, in rare cases, extenuating circumstances such as an officer's injury may preclude a timely interview.

[6] See, e.g., "What Should Happen After an Officer-Involved Shooting? Memory Concerns in Police Reporting Procedures" Grady, Butler, and Loftus, Journal of Applied Research in Memory and Cognition 5 (2016) 246–251.

We noted that interviews of involved and witness officers in the above-mentioned shooting were audio recorded but not videotaped. Thus, the involved officer's description of where he was located in reference to a crime-scene diagram he was shown during MCT's interview was not captured in the audio recording. A videotaped recording would have memorialized not only the officer's testimony but his demeanor, non-verbal communication, and any actions such as indicating on a crime-scene diagram, his location. Involved and witness officer interviews should be obtained in a law enforcement facility with video-taping capability so that demonstrations of movements and positioning can be captured.

We understand that because MCT conducts the criminal investigation, HPD does not determine how officer and civilian interviews are conducted. However, HPD does control the mechanics of any administrative interview and whether it is audio or video recorded. Moreover, as part of membership in MCT, HPD can request that involved and witness officer interviews be video recorded and make their interview rooms or other space[7] available for MCT use as they did for MCT video interviews of civilian witnesses.

A Proposed New Approach for HPD Review

In addition to encouraging HPD to initiate an administrative investigation immediately after an officer-involved shooting, we recommend that HPD incorporate a "phased" approach to its review process. Within a week or two of the incident, administrative personnel should provide an initial presentation to command staff. The goal of this presentation would be to identify those potential issues in policy, training, supervision, or tactics that would be discernible from the evidence that had already been gathered, even if aspects of the full investigation were not complete. This would give the Department an earlier chance to address issues that are time sensitive or otherwise suited for prompt action. Any obvious concerns about individual officer actions as a matter of law, policy or fitness for duty should also be addressed at this time. This initial meeting would likely generate "action items" assigned to specific individuals for completion.

A second phase of the review would be the completion of the comprehensive administrative investigation, including individual accountability and operational issues not identified in the initial review. Performance issues that implicate policy—even if

[7] Our experience is that sometimes officers chafe at being interviewed in interview rooms designed for subject or civilian witness interviews; a more conducive space such as a conference room may be preferable.

separate from the legitimacy or justification of the force itself—should be addressed through the discipline system or other tools available to correct officer behavior, such as training, debriefing or counseling.[8]

Administrative interviews of involved personnel should supplement those conducted during the criminal investigation and provide a comprehensive understanding of the incident, including tactics, decision-making, equipment, supervision and other relevant aspects of the case.

The completion of the administrative investigation should culminate in the convening of a formal Review Board. Many agencies convene a Review Board comprised of command staff, training personnel and other relevant members to review the administrative and criminal investigations as to both individual performance and agency issues. The Review Board provides an opportunity to assess all aspects of the incident with an eye toward learning opportunities and future improvement. The evaluation would consider officer tactics and decision-making, planning and coordination, force option choices, supervision, de-escalation efforts, equipment, training and post-incident responses such as medical assistance and community outreach. Equally important is that involved personnel receive the insight of the Review Board's assessment of the case through targeted debriefing at the end of the process.

We discuss the creation of a Force Review Board in greater detail in Section III below.

Although HPD has a Firearm Discharge policy that includes a Board of Review, it lacks important specifics as to the timelines, scope, or content of the Board's actions. This policy also appears to be limited to firearm discharges only. Many agencies have review boards that evaluate non-hit shootings, in-custody deaths as well as non-fatal critical incidents, such as vehicle pursuits that result in injury, force incidents that result in hospitalization or other incidents that garner media attention and/or create substantial risk. In Section III below, we propose a new model for the Review Board that would encompass these incidents.

In sum, we make the following recommendations to enhance HPD's response to officer-involved shootings, in-custody deaths and other critical incidents:

> RECOMMENDATION 1: The Department should revise its policies to require that its administrative investigation of shootings and other critical incidents commence immediately by appointing HPD personnel to

[8] A comprehensive investigation of, for example, an officer-involved shooting that occurred after a vehicle pursuit, would incorporate an assessment of the pursuit's compliance with policy.

participate in the walk-through of the crime scene, observe MCT's witness and involved officer interviews and actively monitor the ongoing criminal investigation.

RECOMMENDATION 2: The Department should propose that MCT procedures include interviews of involved and witness officers before the end of their shift unless extenuating circumstances such as injury of an officer preclude this.

RECOMMENDATION 3: The Department should revise its policies to require administrative interviews of involved and witness personnel to address not only whether the involved officer(s)' actions complied with policy and training but also to examine areas such as planning, tactics, coordination, de-escalation, communication, force option choices, supervision, equipment and post-shooting conduct.

RECOMMENDATION 4: The Department should revise its policies to provide a timeline, scope and process for conducting the administrative investigation, findings, and written report of officer-involved shootings and other critical incidents.

RECOMMENDATION 5: The Department should revise its review protocols to incorporate time-appropriate phases, beginning with an early, initial debriefing of Department leadership, continuing to a more thorough examination of administrative issues including officer performance, and culminating in a formal Review Board for officer-involved shootings and other critical incidents.

RECOMMENDATION 6: The Department should revise policies to require video recording of its administrative interviews of involved and witness officers and civilians in officer-involved shootings and other critical incidents.

RECOMMENDATION 7: The Department should reformulate its "Firearm Discharge" policy as a Critical Incident policy that includes comprehensive assessment of a wider range of "high risk" encounters, such as non-hit shootings, in-custody deaths, and non-fatal critical incidents such as vehicle pursuits that result in injury, force incidents that result in hospitalization or other incidents that garner media attention and/or create a substantial risk.

RECOMMENDATION 8: The Department should include in its Critical Incident policy a Review Board that is convened at the conclusion of the administrative investigation to evaluate the entire incident and make recommendations. The Board's composition, duties, timelines, meetings and scope should be defined in this policy or elsewhere.

RECOMMENDATION 9: The Department should include in its Critical Incident policy a provision that involved and witness officers be debriefed on any issues/concerns identified by the Review Board.

RECOMMENDATION 10: The Department should provide training consistent with its newly revised Use of Force policy to address officer and supervisor duties when force has been used on a subject including requesting medical assistance, providing life-saving measures, monitoring the subject, and notifying medical assistance as to the force used and the circumstance.

Section Two: Internal Review of Other Uses of Force

HPD's Current Process

We reviewed in detail 65 use of force incidents involving HPD officers that occurred from 2018 to 2020. The majority involved use of hands to overcome resistance to handcuffing, closely followed by use of the Taser, and – relatively rarely – use of a fist or baton to strike or use of a "bean bag" less lethal shotgun. Our impressions of the Department's internal review process were mixed, as discussed below. Encouragingly, we noted examples of thoughtful managerial scrutiny that could become routinized within a different, more comprehensive structure.

Force exerted by an HPD officer that warrants documentation by the officer is termed "reportable force" by HPD policy. However, HPD policy does not explicitly define reportable force. It has simply been described by department members as anything above a low-level hold or other similar physical contact. For clarity, HPD policy should define "reportable force" in its Force policies.

Once the relevant threshold is reached, HPD Force and Post-Force policies provide detailed documentation and review requirements by a sergeant or other supervisor. More serious types of force—those involving particular weapons, types of injuries or more vulnerable subjects require a Supervisor to provide an After Action Report (AAR). AARs require approvals by a lieutenant. An AAR is reviewed by the Watch Commander who finalizes any After Action Closure Recommendations. These include a determination of whether the action was within policy, remedial training recommendations, and requests for additional review by the training division and/or Force Response Review Board. All AARs require additional review by the Division Commander and the Deputy Chief. (Post Force Response Process and Reporting, Policy 302). The review process was enhanced, including additional levels of review, after a use of force incident in the jail booking area, described below, resulted in civil litigation. This demonstrated to HPD leadership that additional checks and balances would be helpful.

Although HPD's annual Use of Force reports provide statistics for the frequency of a "show of force," such as pointing a gun, HPD's Force and Post-Force Reporting policies do not define what constitutes a "show of force" or officer's reporting and documentation requirements. HPD should revise its policy to incorporate these requirements and definition.

> RECOMMENDATION 11: HPD should modify its Use of Force policies to define reportable use of force.
>
> RECOMMENDATION 12: HPD should modify its Use of Force policies to define "show of force" and any duties officers and supervisors have concerning the reporting, documentation and review of show of force conduct.

Keys to Effective Review: The Need for Issue Spotting and Responsive Intervention

1) Require Supervisors to Independently Assess Whether Force Is in Policy and Identify Problematic Uses of Force.

The After Action Report is currently the foundation of the Department's review and evaluation of its own use of force. If an incident warrants subsequent scrutiny, it begins with the AAR. We found a wide range of quality within the AARs we looked at: some

were terse and formulaic, while others were elaborately constructed and sophisticated in their evaluation of events.

Others show skill and rigor in their analysis but lack some key element. In one case, for instance, officers were serving a felony arrest warrant at the subject's residence when the subject ran out the back door. Seeing other officers stationed there, he turned and tried to run back inside. Officers used a Taser, which missed, then grabbed the subject before he could get back into the house. The AAR laid out a clear narrative of events, added useful detail based on the sergeant's own observations, then analyzed the force employed by the officers in a systematic way and specified and applied Department policy. This appeared to be an exemplary AAR except that the sergeant acknowledged not reviewing the body-worn camera footage in the case, essentially declaring that the after action review was incomplete.

In another example, officers responded to a suicidal teenager who had assaulted his parents. Despite the young man's large knife and the constant threat of self-harm, the officers maintained a calm, slow, deliberate approach, eventually separating the subject from the knife and using minimal force to place him in a full body restraint. The problem, accurately identified by the sergeant who wrote the AAR, was that the officers had used appropriate force but had failed to report it and may not have understood the difference between reportable and "de minimus" force. The cogent analysis provided the Lieutenant reviewing the case with the necessary information to recommend remedial training for the officers aimed specifically at these force policy definitions and the need for accurate reporting. However, the AAR was not written until four months after the incident, unnecessarily delaying the referral to remedial training on a fundamental issue and weakening the constructive impact of the analysis.

To some extent, structure and length variations of AARs are understandable: some uses of force are fairly straightforward, while others require an evaluation of how various aspects of HPD's force policies apply to a complicated set of facts. Regardless of an incident's complexity, though, a fundamental component in every After Action Report must be objective analysis. If this is missing, a troubling incident may elude appropriate scrutiny. This in turn deprives the Department of the opportunity to correct an officer's performance, modify a policy, avoid liability, or prevent an erosion of public trust.

The baseline component of an effective force review system is that it requires supervisors to identify problematic uses of force.

In one case we reviewed, an officer punched an elderly DUII arrestee in the head with a closed fist when he became verbally threatening during the booking process. The officer described the punches as a "focused blow" to distract the arrestee from trying to hurt him. The sergeant's AAR went into compelling detail about the facts reported in the

incident reports and the surveillance video but found the force in policy. Appearing to rely solely on the sergeant's After Action Report without viewing the jail video, the reviewing lieutenant and now-retired commander concluded the use of force was in policy. None of these reviewers analyzed whether the officer's use of a "focused blow" with a closed fist to the head was appropriate and in policy. Not until the arrestee filed a civil lawsuit causing greater scrutiny of the incident internally[9] was the officer's use of force appropriately scrutinized both administratively and criminally.[10]

Moreover, it appears that initial reviewers treated this incident in isolation instead of considering numerous other incidents of the officer's problematic conduct. These included a public complaint and several other administrative investigations involving poor communication, impulsive decision-making, previous use of "distraction blows to the head" (questioned by reviewers), and involvement in a pursuit found out of policy. Some of these incidents resulted in findings of out of policy force and referral for remedial training. Ultimately, in the jail booking incident, HPD's more in-depth review (that to the Department's credit, it conducted in response to the civil lawsuit filing) concluded that the officer's two blows to the subject's head were unreasonable and disproportionate. This subsequent history reinforces the idea that the case merited a more robust initial assessment, not only for its basic legitimacy but also in terms of the practical alternatives available under the circumstances: namely, a jail setting with ample law enforcement backup.

The jail surveillance video of this incident showed a use of force that raises questions about its necessity and the technique used. Strikes to the head are considered by police trainers to be unnecessarily dangerous to both the officer and the suspect. Engaging these questions immediately with a Professional Standards investigation could have provided benefits that go beyond the matter of any remediation or accountability for the officer. Internal investigations often grapple with whether policies and training are well understood by officers in the field or are perhaps viewed as impractical or optional. This process also helps the Department refine its policies and training or address gaps in same, for instance the absence of language specifically addressing blows to the head in the HPD Policy Manual.

---

[9] In compiling discovery materials for the lawsuit, the jail video of the incident was reviewed and sent to command staff. The review of that video prompted a reopening of the investigation and a reassessment of the findings.

[10] After reviewing the incident, the District Attorney declined to file criminal charges against the officer, stating that "When viewed in isolation, the actions of [the officer] may seem heavy-handed at first; however, when taken in full context and considering the factors at play, they were not." As is customary, the District Attorney did not address the question of whether the officer violated HPD policies.

The investigation should also have triggered a consideration of whether the use of distraction blows should be limited by Department policy.[11] The theory of "distraction blows" is that a strike is effectuated in order to distract the subject so that h/she can be effectively handcuffed and brought into custody. However, because of the danger of serious damage as a result to blows to the head or other sensitive areas, progressive policies guide officers to prohibit strikes to the head, groin, or other sensitive areas.

Moreover, using a closed fist to effectuate such strikes provides a heightened risk of injury to both officer and subject; officers are trained and advised to deliver such strikes using a palm. Finally, progressive policies advise officers to re-evaluate this force option if not effective and limit the frequency to three strikes.

> RECOMMENDATION 13: Supervisors and subsequent reviewers in the chain of command should consider and analyze the efficacy and appropriateness of all uses of force within the incident.

> RECOMMENDATION 14: The Department should provide further guidance to its officers by prohibiting distraction strikes to the head and other sensitive areas, requiring delivery of such strikes with the palm, and limiting the number of distraction strikes.

2) Provide Internal Deadlines for Timely Completion of AARs and Their Review

HPD's Force and Post-Force Reporting policies does not include internal deadlines for supervisor review of incidents and completion and review of After Action Reports. In some cases, we noted significant delays between an incident and the completion of an AAR. It was not unusual for a month or even two months to go by before the AAR was submitted. Some delays were four months or more. Such delays mean that the Watch Commander or Division Commander who may be reviewing the AAR is considering an incident that occurred many shifts ago, thereby diminishing the effectiveness of feedback – or the timeliness of accountability – that the involved officers may ultimately receive.[12]

3) Require Non-Involved Supervisors to Complete After Action Reports

---

[11] Distraction strikes are not addressed by current HPD policy.

[12] We have been advised by HPD that since last year direction to supervisors is that AARs need to be routed to the patrol commander within 30 days but policy has not yet been devised to reflect this expectation. We appreciate the recognition of the need to develop internal guidelines and urge HPD to ensure adherence through development of written policy.

Given the importance of objectivity to effective analysis, there is significant value in requiring non-involved supervisors to conduct the agency's use of force reviews. However, HPD's Post- Force Response policy does not explicitly feature this requirement.

We reviewed an AAR in a case where the reviewing sergeant had taken part in the use of force by "going hands on." We noted two problematic aspects of the sergeant's conduct. First, by becoming physically involved in the incident, a supervisor can no longer perform their vital supervision and coordination roles. It contradicts most standard supervisor training.

Although there may be a rare occasion where extenuating circumstances may justify a sergeant's physical involvement, most situations that we reviewed involved an ample number of officers, making a sergeant's tactical involvement unnecessary and inadvisable.

Second, regardless of whether the sergeant's physical engagement was warranted, the fact of its occurring should sideline those individuals from handling the resultant AAR. Requiring a supervisor to review their own actions—including their supervisory decision-making— undermines the objective, robust scrutiny required for accountability. We saw several examples of this problem in 2018 and 2019, though the number of AARs written by sergeants who had gone "hands on" diminished greatly in 2020. We have been advised that the diminution of sergeants evaluating their own uses of force is a result of practice that was not codified in policy. To that end, HPD should draft a policy specifically instructing supervisors not to review force incidents in which they were involved or directed the use of force.

HPD should draft policies that discourage sergeants from using force in an incident when they are on scene in a supervisory role unless the circumstances require their hands-on intervention. Additionally, HPD's policy should require the review of force incidents by non-involved supervisors.

> RECOMMENDATION 15: HPD procedural guidelines should state that After Action Reports must be completed within a week of the incident in question, barring special circumstances, with extensions requiring supervisory approval.
>
> RECOMMENDATION 16: HPD policy should be revised to require non-involved supervisors to review force incidents and draft After Action Reports.

RECOMMENDATION 17: HPD should devise policy and appropriate training instructing sergeants to avoid becoming involved in uses of force unless their active participation is necessary and instead directing them to assume a supervisory role over the incident.

4) Evaluate Alternate Force Options During Force Review and Evaluate All Personnel Involved

An effective use of force review process includes not only an evaluation of the use of force involved in the incident but also alternative force options that were available to the officer that could have minimized or avoided the use of force. Additionally, it is imperative that all personnel involved in the incident be included in the use of force review:

Two officers responded in the early morning darkness to 911 calls of a prowler climbing fences, attempting to open doors and windows of homes, and yelling. They encountered an unarmed, non-compliant and extremely intoxicated subject on the back porch of a mobile home. He refused their commands to move away from the residence and began banging a large mirror that broke into shards. BWC footage showed that as he started to flee by grabbing the top of a 6-foot fence and then hoisting himself onto a water heater to climb over, an officer fired a Taser.[13]

In this case, the subject fell backwards, hitting his head on a nearby wooden railing and landing on shards of the broken mirror.

The officer's police report indicated the subject had a bloody knuckle and a cut lip. Although photographs of the subject handcuffed were taken at the scene, none included his injuries. Nor did the officer's police report include any information about the hospital's assessment of the subject's injuries.

The first After Action Report by a sergeant summarized the subject's conduct and found the officer's use of a Taser reasonable. This report did not address a seemingly relevant portion of HPD's Taser policy, which states that proper consideration and care should be taken in deploying a Taser on subjects who are in an elevated position or in other circumstances where a fall may cause substantial injury or death. Nor did it consider alternative force options. Instead, the AAR provided a "Perception-Reaction

[13] A Taser, or conducted energy device, is a less lethal force option that uses electrical current to temporarily incapacitate a subject. We discuss its properties, and the review process it specifically merits, in more detail below.

assessment" that focused on officer decision-making, response times, and changing environments to ultimately conclude the officer's use of the Taser was within policy.

The lieutenant who reviewed the sergeant's AAR wrote his own AAR.[14] Importantly, the lieutenant noted HPD's Taser policy that cautioned against the use of Tasers on subjects in an elevated position, a relevant inclusion that improved upon the sergeant's review. This reviewer believed the officer likely decided to discharge the Taser before the subject reached the top of the fence and concluded that the officer's Taser use was within policy. Despite finding the Taser use in policy, this second reviewer recommended additional training regarding circumstances in which Taser deployment may not be appropriate as well as alternate responses in similar situations. While the recommendation for additional training was certainly merited, we had concerns that its effectiveness was undermined by an "in policy" finding that reinforced the conclusion that the officer's conduct and decision-making met the Department's standards. The lieutenant's AAR report did not explain this seeming incongruity.

The review of this incident could have been enhanced in several ways. First, the reviewers' focus on whether the subject had reached the top of the fence at the time of Taser deployment appeared misplaced. The BWC footage showed the subject climbed the fence and was Tasered, fell backwards and struck his head—an outcome which officers are cautioned to consider when deploying a Taser. The After Action Reports did not ultimately grapple with the important question of whether Tasering was the appropriate response to an unarmed, intoxicated, non-compliant trespasser who was fleeing by climbing a six-foot fence. Nor did the reviewers ever address other force options, including the option suggested during the incident: to grab the subject.

Second, a comprehensive evaluation would have addressed both officers' conduct and included important aspects of the events and decisions leading up to the use of force. For example, the BWC video included both officers engaged in effective planning (including one officer's suggestion to wait for more back up), a concern that the suspect might escape, and ultimately, a plan "to grab him" if the subject attempted to escape. This incident provided an opportunity to point out effective conduct and also address important concerns about deploying a Taser at an elevated subject.

[14] Some incidents merited a second AAR by a Lieutenant or Commander or a similar review in memo form. These were usually astute expansions on topics not fully addressed in the original AAR, but there was no standard documentation about why they had been deemed necessary.

Third, de-briefing and retraining should have been provided not only to the officer who deployed the Taser, but also all involved officers, including those at the scene and the sergeant who wrote the first AAR.

Ultimately, this incident would have benefitted from the comprehensive discussion of a Force Review Board. This review would have provided HPD an opportunity to review tactics, force options and training for handling non-compliant intoxicated subjects who are attempting to flee. In particular, it offered a distinctive chance to consider the risks and benefits of deploying a Taser under these circumstances. HPD's current approach—especially as embodied in the first After Action report—meant that the learning or growth opportunities that the incident presented were not fully exploited.

HPD has recently updated its Taser policy. It now requires a warning and time to comply before deployment and also instructs that mere flight from a pursuing officer is not good cause for deployment. This commendable change was overdue and is in keeping with best practices. Aspects of this incident as discussed above, however, still point to shortcomings in internal review of uses of force that were not addressed by the policy change. The two recommendations below are not specific to Taser incidents but apply to the Department's after action evaluation of many of the force incidents we reviewed.

> RECOMMENDATION 18: Supervisors and subsequent reviewers writing After Action Reports should consider the threshold question of why an action was taken and whether there were preferable alternatives that could reasonably have been considered.

> RECOMMENDATION 19: After Action Reports should evaluate the actions and decision-making of force users as well as supervisors or others involved in the incident in any manner relevant to the use of force.

5) Address Collateral Issues

When force incidents are reviewed, it is incumbent upon the agency to identify and address the relevant non-force issues that may be implicated, such as other procedural matters that bear on the rights of the subject and the legality of police actions. For example, in one force incident we reviewed, an officer rapidly exited his vehicle soon after dispatch reported two males stealing shoes from a local shoe store. Without warning, the officer shoved a female who was walking nearby, sending her to the ground, and then chased a white male who met a suspect description and was carrying a bag of shoes.

The officer later justified his use of force against the female by citing the dispatch report that the theft involved a third person; he saw the female in proximity to the male and connected her to the alleged crime. However, she was an uninvolved employee from another store who was on her lunch break and was visibly – and understandably – upset by what had happened.

Apart from the inherently problematic nature of this mistake, there were other flaws in the officer's handling of the incident. Although he creditably returned to the female and apologized for his actions, he did not notify a supervisor of the force. Accordingly, no supervisor came to the scene to conduct a use of force investigation, which should have included an interview of the female.[15]

The After Action Report found the use of force against the female in policy, a conclusion we found problematic in light of the female posing no threat to the officer. Additionally, the AAR never addressed whether the officer shoving the female to the ground was appropriate even though there was no description of any female being involved with a theft from the shoe store and nothing about her demeanor or actions indicated involvement in the theft.

Additionally, we reviewed force incidents where officers searched rooms or residences but made no reference to the exigency, consent, public safety considerations or other circumstances that would justify those searches.

> RECOMMENDATION 20: The Department should require analysis of any other failures to comply with law or policy that arise in the course of a use of force investigation

6) Clarify Body-Worn Camera Procedures

Body-Worn Cameras (BWCs) have greatly aided fact finding, training and accountability in policing. They can provide law enforcement managers a powerful new tool to see how their officers actually perform in the field. They are, for instance, a vital source of information for the After Action Report writer. But law enforcement agencies have to meet the challenge of arranging the procedures surrounding BWCs in a way that is clear, practical and fair. HPD has made some rules but left officers to improvise about others. This leads to inconsistent procedures and cause some members of the public to believe that HPD is not recording information that might place its officers in a negative light.

---

[15] To the reviewer's credit, he noted that the officer did not notify a supervisor concerning his use of force as is required by HPD's policy and discussed with him this requirement.

One issue is frequent turning off and on of the sound. HPD officers often deactivated the sound recording component of their BWCs during a call for service when officers were conversing with one another rather than interacting with a suspect or witness. One supervisor opined that this is not a rule but rather a custom based on the rationale that, officer conversation has little evidentiary value and that officers are apprehensive that their word choice or turn of phrase in the field will be used against them in an unfair way. We have two concerns with this approach.

First, as a custom, it produces inconsistent results. Some incident footage will contain sound of conversations; some will not. This can produce the impression that the BWC user is making choices based on the anticipated content of the conversation. Second, there is also often clear evidentiary value to what officers and subjects say in the field.

In one incident we reviewed, the arresting officer administers field sobriety tests following a DUII arrest and then approaches a sergeant, who turns his BWC sound off. The officer appears to describe the cause for the arrest to the sergeant, then returns to the subject to handcuff and place him in the patrol car. The subject appears to become verbally agitated while the officer remains calm and professional, but the sound has remained off so we cannot tell what is said or how. The subject's verbal behavior is relevant to any subsequent prosecution for DUII – potentially indicating level of intoxication and rationality.

Similarly, in a case involving deployment of a canine, the audio of the canine tracking was muted, thereby failing to record the canine handler's mandatory warning.

HPD's BWC policy instructs members that their BWC "shall be activated…When a person is in custody or being detained." [HPD Policy Manual 435.3].[16]

These examples also demonstrate another problem with turning the sound off: the user may easily forget to turn it back on. This too creates inconsistent results and may give the impression of intention for what can simply be inadvertent distraction. For the above reasons, HPD should revise its BWC policy to make it clear when BWC's should be activated. The policy should instruct officers that the video and audio of their BWC's should be activated whenever engaged in interaction with the public, including capturing

[16] The BWC policy is silent on whether leaving the camera on but the sound off is adequate but generally, BWC activation means activation of both sound and video.

conversations between officers and the public as well as among officers when connected to the call for service.[17]

The Department's policies also do not specify whether an officer, in preparing an incident report, may, should or must view the BWC footage before writing. Officers have taken to inserting a stock paragraph at the beginning of their incident reports that states that either the officer based the report on the video or based it on his or her recollection. Sometimes it remains unclear whether the officer viewed the video or not before preparing the report.

HPD policy should be changed to provide clearer direction to officers. When preparing a report in support of a citation or arrest, officers should be required to review their BWC video of the event and the fact of that review should be included in the report. In situations where the conduct of the officer is at issue (complaints, use of force, internal affairs investigations), the officer should first be interviewed about the event so that a pure statement may be obtained. The interview should then be paused and the officer provided an opportunity to view any recordation of the event. If the review of that recording refreshes the officer's recollection of the incident, the officer should be afforded an opportunity to supplement his response.

> RECOMMENDATION 21: The Department should revise its BWC policy to advise its officers to activate both video and audio features when dealing with the public except in narrowly specified exceptions.

> RECOMMENDATION 22: The Department should revise its BWC policy to require officers to review footage when preparing an incident report in support of an arrest or citation but to refrain from review in cases in which the officers' conduct is at issue (such as a use of force, complaint, or internal affairs investigation) until a pure initial statement can be obtained.

7) Measure Progress in Responding to Mental Health Crises

We have been told by HPD staff that, in recent years, there has been a steady rise in calls for service related to a member of the public in a mental health crisis. These often result in a "peace officer hold," when a peace officer takes into custody "…a person who the officer has probable cause to believe is dangerous to self or to any other person and is in immediate need of care, custody or treatment for mental illness,"[18] and transports

---

[17] The circumstances when BWC activation should not occur should be limited to times in which officers are not engaging with the public or are in places such as hospitals where privacy concerns may override the interest in recording the event.

[18] ORS 426.228

that person to a hospital. Of the sixty-five use of force incidents we reviewed, more than 50% were peace officer hold cases or otherwise involved a mental health crisis.

HPD has recognized the challenge presented by this rise in mental health crises that it is called upon to handle. One positive aspect of its responsive efforts is its deployment of the "WRAP" restraint and, more importantly, its well-rehearsed application in contexts involving mental health issues. The WRAP is a large, reinforced fabric restraint that can immobilize the legs to the waist and, to a lesser extent, restrict torso and head movement. When properly applied by a team of officers, it can keep a subject from hurting themselves or others until they reach the hospital. We did not encounter incidents where the WRAP was ineffective or caused an injury.

Approximately half a year ago, the Department also dedicated one officer to participate full time in the county's Mental Health Response Team (MHRT), a program that pairs a trained crisis clinician with a law enforcement officer and a patrol car. Together they respond to mental health calls for service. Additionally, HPD is now providing the funding for half of a full time county clinician for MHRT. The HPD officer in the program volunteered for the assignment and received extensive additional training. The members of MHRT teams identify persons in their area at risk for mental health emergencies and check in with them periodically when they are not responding to calls.

In our review of use of force incidents involving a mental health crisis, we observed documentation of the involvement of the MHRT unit only once. Nor did we see other references to conferring pre- or post-incident with MHRT to see if the team was familiar with a particular subject and could offer advice or direct assistance. Department decision-makers may want to gather data to evaluate whether MHRT's expertise is being fully utilized and whether greater investment on the part of participating law enforcement might yield greater assistance with a growing problem with which all agencies must grapple. Currently, the MHRT teams operate only half of each 24-hour day. If HPD leadership determined that more mobile teams or round-the-clock coverage were warranted, they could consider training and dedicating more officers to the effort and urging the county to provide more resources for more clinicians.

We were informed that HPD has recently augmented its capabilities for responding to problems amplified by homelessness and/or mental illness by dedicating two officers to its homeless liaison team. Since, based on our sampling of use of force incidents, responses to mental health crises appear to have a high correlation with use of force, the Department should attempt to quantify the observed benefits of targeted changes like this by evaluating relevant statistics periodically.

> RECOMMENDATION 23: The Department should quantify the effectiveness of any initiatives it takes to mitigate targeted problems such

as mental health crisis responses, including deployment of special equipment, techniques or personnel, by establishing a baseline of relevant statistics[19], then periodically compiling measurements of any changes.

Specific Force Options: Using the Review Process to Adjust Officer Performance

1) Prohibit Multiple Simultaneous Deployment of Tasers

The Taser is conspicuous for its frequency of use in HPD force incidents and figured prominently in the "fence-climbing" case we discuss at length above. A Taser is a directed energy weapon that shoots two barbed probes over a short distance and painfully paralyzes a large portion of the person it hits during the standard 5-second flow of electricity through the wires connecting the prongs to the energy source held by the officer. The advantage of the Taser is that it usually[20] causes no lasting injury. It is best used to assist handcuffing a threatening or violent person without using an impact weapon or greater force option. This can be accomplished in a very short time –– if the officers work as a team and initiate handcuffing immediately while the subject is "under power." All Taser activations produce a data trail, a printout of which is made part of each use of force file where a Taser was used. Our examination of the use of force files and data showed no Taser uses that exceeded ten seconds. This usually indicates an efficient, controlled use of the weapon. Based on our review, HPD officers appear to be well trained in the use of the Taser and usually deploy it using proper technique.

But some Taser uses by HPD and the Department's After Action evaluations have raised our concerns, including the Taser deployment discussed above. In one instance, two officers had not coordinated their Taser use and shot their Tasers at the suspect simultaneously. Fortunately, only one Taser was effective, but one of the Taser probes hit the subject in the eyebrow. Taser manufacturing guidelines now advise to avoid the face, neck and part of the upper chest, so as to minimize lasting injury. While the AAR for this incident mentioned the simultaneous use of two Tasers, it did not identify that as an issue, nor did it comment on the failure to stay within the safer target zone. We note

[19] For mental health crises responses, for instance, these could include number of calls for service, outcome of the response, force used, injuries, and number of previous responses regarding each subject.
[20] Tasers have also been deemed a contributing cause of death on some occasions by US courts, especially when two Tasers were fired simultaneously at the same subject or the subject was subjected to very extended exposure to Taser electricity cycles.

that HPD's updated Taser policy now warns officers against intentionally applying more than one Taser at a time against a single subject. (Policy 310.5.4 Conducted Energy Device).

> RECOMMENDATION 24: Field supervisors and subsequent reviewers should ensure that all aspects of HPD's current policy and training are considered in evaluating Taser deployments.

2) Enhance Systems for Canine Use and Review of Canine Force Incidents

OIR Group reviewed three canine use of force incidents. HPD's practice of requiring an After Action Report after canine deployment is an excellent one. However, as discussed below, we recommend that HPD incorporate more careful scrutiny and review of canine deployment cases, including their presentation to a Use of Force Review Board. Additionally, by limiting its current review to focus exclusively on whether canine deployment is justified, the Department is missing a vital opportunity to assess the entire incident and improve the quality of its response by all involved officers (not just K-9 handlers) in future operations.

HPD responded to Washington County Sheriff Office's (WCSO) request for canine assistance to locate three subjects reportedly involved in an assault and robbery. Computer Assisted Dispatch (CAD) notes indicated the victim was punched and her phone taken. Dispatch described the suspects as two white 21-year-old males and a 19-year-old Hispanic female who had left the scene on foot and were heading north.

An HPD officer with his K-9 arrived and searched the surrounding area for the next hour. According to the K-9 officer, when his dog showed increased interest in the heavy brush along a trail, the HPD officer gave several K9 warnings. The HPD officer then released his K-9 from his leash with a bite command into the heavy brush. Shortly thereafter, a voice called out they were in the brush, the HPD officer called his K-9 back and two males and a female emerged from the brush and were taken into custody without incident. One of the males said the K-9 had brushed his face, but none claimed to have been bitten.

The officer's justification for deploying the K-9 included: 1) probable cause to arrest all three suspects for Robbery II and Assault III; 2) the initial 911 call stated one of the people had a knife; 3) the officer could not see through the heavy brush;4) no one had responded to the officer's numerous K9 announcements; 5) the suspects were a danger to others and the officer; and 6) the suspects were actively hiding from the police.

The sergeant's After Action Report found the officer's deployment of the K-9 within policy. The sergeant also noted that the officer's body-worn camera was muted during

the K-9 tracking and that muting should only be done in extenuating circumstances. (The sergeant should have pointed out that by muting the audio during the K-9 tracking, none of the K-9 officer's warnings were recorded.) The sergeant also observed that the K-9 had not engaged the suspects despite the officer's "bite" command. The sergeant recommended follow-up training concerning the K-9's failure to engage and capturing BWC footage including audio during K-9 tracking. Seven weeks later, a lieutenant signed the sergeant's After Action Report and made no additional comments.

The observations and recommendations that the reviewing sergeant did make were effective examples of scrutiny. But there were other relevant components that did not receive the warranted attention.

For example, although the K-9 officer stated that probable cause for robbery and assault charges existed for the suspects, the K-9 officer's report did not include a factual basis for arresting the subjects. Alternatively, in light of the K-9 officer's reliance on the Sheriff's representation of probable cause, a copy of the Sheriff's incident report would have provided this important information.

Another missed issue in the review was a significant mistake of fact. The HPD officer justified canine deployment in part because the incident involved a knife. However, CAD notes indicated that the victim—not the subjects—had a knife; moreover, the victim informed dispatch that there may be a video showing the victim "holding a knife to one of the suspects." That this misunderstanding played a prominent role in the officer's threat assessment is obviously noteworthy.

The K-9 officer released his canine off leash and into a brush area accessible to the public and during the early morning hours when it was still dark. It did not appear that the accessibility to the public and the possibility of inadvertent third-party contact with the dog was part of the officer's assessment.

Among the missing elements in the file were WCSO's incident reports[21] and any reference to subject charges and their status. This information is critical to a

[21] Washington County Sheriff reports were included in another Use of Force file reviewed by OIR Group that involved the Sheriff's request for assistance from HPD's K-9 unit. However, HPD's Use of Force file involving canine deployment on the three suspects did not have comparable reports; nor was there any documentation that HPD attempted to but was unable to retrieve Washington County Sheriff's reports for its own process. OIR Group recommends that all incident reports, including those from outside agencies, be included in the Use of Force file, and that HPD document its unsuccessful efforts to obtain those reports as applicable.

comprehensive review. Nor was a closure memo concerning the sergeant's recommendation for remedial training included in the file we reviewed.

A second canine case involved a subject engaged in erratic and increasingly violent behavior. This included running into traffic and attempting to forcibly take a woman's car keys in an effort to flee from pursuing HPD police in her vehicle. The HPD K-9 officer deployed his canine off leash as the subject was fleeing. The canine knocked the subject to the ground and continued biting the subject for 24 seconds while three officers arrived on scene and assisted in handcuffing and taking the subject into custody.

The reviewing sergeant prepared an After Action Report that focused exclusively on justifying the deployment of the canine. While OIR Group has no concerns with the reviewing sergeant's and K-9 officer's reasoning for canine deployment, HPD's review was again too narrow in focus and missed important issues that a more holistic approach would have provided. For example, it did not appear that the K-9 officer, his supervisor or command staff discussed the conflicting commands by officers and how it may have delayed taking the subject into custody ("get on your stomach"; "get on your back"). This incident provided an opportunity to assess communication, handcuffing and coordinated responses of the officers and evaluate what steps, if any, could have been taken to bring the subject into custody more efficiently.[22]

A third canine case involved HPD's K-9 assistance when a subject abandoned his motorcycle and fled into a residence after a WCSO deputy attempted to conduct a traffic stop. The home was associated with a subject known to HPD officers who had an active felony state parole arrest warrant and had resisted arrest in the past. However, the motorcyclist's identity had not been confirmed before he ran inside the residence.

HPD's K-9 officer searched the residence with his canine on leash; he gave warnings and then commanded his canine to search and bite. Upon observing muddy footprints that led to an attic access, the K-9 officer used his body-worn camera as a pole camera to view inside the attic but could not see anyone. While standing on a dilapidated pull-down ladder to the attic, he gave a warning and deployed his canine inside the attic with search and bite commands. Although the officer observed the canine pick up a blanket with his mouth several times, there were no indications or alert of a subject. Several hours later, Washington County Sheriff's deployed its own K-9 into the attic, located the subject, and took him into custody. The subject stated he had received bites from both

[22] Factors that can affect whether the force is reasonable include duration of the bite, actions taken by the officers after the dog has engaged, and actions taken by the suspect. *Watkins* v. *City of Oakland*, 145 F.3d 1087 (9th Cir. 1998).

canines and that the first canine had bitten him on his head and arm. The subject was taken to the hospital and treated for his injuries.

To HDP's credit, this 2020 incident was the subject of three After Action Reports – two of which showed particular thoughtfulness. The first After Action Report, however, was by a reviewing sergeant who essentially restated the K-9 officer's justification for deploying his canine.[23] Fortunately, the analysis became more comprehensive during the subsequent reviews.

The second After Action Report by a lieutenant distinguished between the use of a K-9 to locate the subject and the reasonableness of directing a K-9 to bite a subject absent any indication of physical resistance, assault or attempted assault on an officer or others. This reviewer found that the subject's crimes of eluding an officer and unlawful use of a vehicle[24] did not justify the level of force of a direct K-9 bite.

The lieutenant also pointed out important differences in how the two agencies conducted their K-9 search. The lieutenant noted that HPD's K-9 officer stood on a broken dilapidated pull- down ladder[25] to look into the attic, gave dual commands to "search and bite" while the K-9 was on line, and observed his canine grab and pick up material but did not see or hear anyone call out. In contrast, the Sheriff's team formulated a plan that included replacing the dilapidated ladder with a utility ladder that could hold the weight of multiple team members. The handler attached a camera to his canine that permitted the handler to view the monitor and directed his canine to search off leash. The handler was able to observe the behavioral change in his canine and could see on the monitor that his canine was tugging on material in an attempt to get the subject. Once alerted, the Sheriff's team entered the attic and took custody of the subject without further incident.

Ultimately, the Lieutenant recommended remedial training to address the deployment of canines in tight quarters and to follow HPD's policy of "Bark & Hold" to minimize non-directed canine contacts. The reviewer also recommended that the incident be reviewed by HPD's Training Division.

HPD's Commander wrote a third After Action Report after reviewing the reports, BWC footage, two Ninth Circuit Court of Appeal decisions involving canine bites, and

---

[23] While we saw instances of careful analysis from HPD's reviewing sergeants, their AARs (as in this case) too often limited their analysis to the moment force was used instead of evaluating the entire incident with an interest in identifying lessons learned.

[24] HPD confirmed that the subject's motorcycle was stolen.

[25] The ladder was so unstable that when the K-9 officer retrieved his canine, they both fell off the ladder and landed on the deputy below; fortunately, none of them were injured.

speaking with the lieutenant who wrote the 2nd After Action Report and the K-9 Team. He concluded that the application of force was reasonable in light of the treacherous environment in the home and the subject's criminal history, including the underlying crime of felony eluding. The Commander characterized this case as falling within the "hazy grey area between reasonable and unreasonable force" and stated he would have desired that the canine be used initially as a search tool upon entering the residence. Then, after alternatives such as commands to surrender and the pole camera were used, the canine could be used as a force option, preferably on leash to bolster the handler's ability to control and call off the canine as necessary.

It is commendable that the Department's review of this incident included thoughtful analysis from two reviewers. However, many of the salient points and recommendations from the lieutenant were never addressed in the subsequent reviewer's AAR. Moreover, for force incidents resulting in injury such as this canine deployment, it is imperative that review not simply end with an After Action Report, but rather that the incident be presented and discussed from multiple perspectives before a Force Review Board. Applying such a review to canine deployment cases would signal the Department's commitment to learn from the incident and grapple more effectively with the unique complexities of this force option.

Lastly, the Department should strengthen its data collection, analysis, and reporting on canine use. The Department's K-9 Unit has recently started collecting 2021 data concerning its canine teams. We recommend that the Department regularly collect and review canine data to identify trends and potential outliers.[26]

The Department's public reporting of canine usage data has been sporadic and incomplete. The Department's 2020 Use of Force Summary identified only one canine case – a clash with the two such cases resulting in injury that we looked at. Similarly, the Department's 2019 Use of Force Summary did not include the 2019 canine case we reviewed, and canine contact was not even listed among the Department's force options. We recommend that the Department regularly publish its canine usage statistics on its website as part of its Use of Force Annual Report.

In sum, we make the following recommendations concerning the Department's use of force incidents involving canines.

---

[26] The Police Executive Research Forum points out that many agencies regularly monitor their canine teams' "bite to deployment" ratio and investigate when a team's deployment results in an increase in bites. Guidance on Policies and Practices of Patrol Canines, Police Executive Research Forum, May 2020, https://www.policeforum.org/assets/Canines.pdf

RECOMMENDATION 25: The Department should revise its canine policy to require that K-9 officers include the factual basis for arrest for subjects against whom a canine is deployed.

RECOMMENDATION 26: The Department should develop policy accompanied by supervisor training to ensure a holistic review of canine incidents that includes the performance of all involved personnel (not just K-9 handlers) as well as issues of planning, tactics coordination, de-escalation, force option choices, communication, supervision, equipment, training, policy and post-incident conduct.

RECOMMENDATION 27: The Department's review of canine deployment should include an evaluation of what steps, if any, could have been taken to minimize the duration and number of canine bites.

RECOMMENDATION 28: The Department should require that its Use of Force files include documents and police reports from outside agencies that are involved or have relevant information about the Department's use of force incident.

RECOMMENDATION 29: The Department should require that subject charges and their status be included in the Department's Use of Force file.

RECOMMENDATION 30: The Department should require that the implementation of After Action Closure Recommendations be documented in a closure memo that describes the remedial training, policy change or action taken and kept in the Use of Force file.

RECOMMENDATION 31: The Department should require that canine deployments involving injuries be reviewed by a Use of Force Board.

RECOMMENDATION 32: The Department should regularly collect and review canine data to identify trends and promptly investigate outlying numbers.

RECOMMENDATION 33: The Department should regularly publish its canine usage statistics on its website and as part of its Use of Force Annual Report.

Section Three: More Robust Evaluation of Incidents Through a Use of Force Review Board

Principles of a Force Review Board

Many law enforcement agencies assemble a group of supervisors and subject matter experts from within the agency to review significant uses of force by the agency's officers. As we have commented above, especially with regard to complex incidents and thorny topics of policy and performance in the field, the comprehensive discussion, analysis and action plans available through a force review board can produce constructive learning.

The benefits of a force review board include the following:

- Executives and other decision-makers have a periodic opportunity to see in-depth how officers are responding to the most significant challenges of field operations.
- Board members get frequent exposure to the thinking and experience of subject matter experts within the Department.
- Board members can observe early indications of crime trends in their community as well as trends in use of force or particular weapons or techniques by officers.
- Decision-makers can confer and strive for consistency and fairness in setting Departmental expectations for officers regarding use of force.
- Board members can collaborate on the best means to remediate policy, equipment or officer performance issues.

HPD currently has a force review board in name only.[27] Department policies provide for a review of certain force incidents by some sort of board, but none of the HPD

[27] Although HPD's Firearm Discharge and Post Force policies call for a "Board of Review" and "Force Review Board, HPD staff could not recall the convening of any Board to review an officer-involved shooting case or other force incident. (Discharge of Firearms with No Human Injury, Policy 305 and Post-Force Response Process and Reporting, Policy 302) Policy 302 requires an investigation and authorizes the Chief to convene a Force Review Board (FRB) when necessary to help evaluate a force incident but explicitly prohibits the FRB from "recommending any action related to the involved employees." This policy instructs the FRB to "complete a summary report and forward it to the Division Commander, who will review the report and determine whether any further action is needed." HPD's previous Post-Force

personnel we interviewed could recall when the last one was held. To its credit, HPD leadership has expressed an interest in a revived and reimagined Board.

Whether a force review board becomes a meaningful and constructive feature of a police agency depends on several factors – foremost among them a clear and comprehensive sense of purpose. The main idea is a straightforward one: that significant force incidents are inherently deserving of an agency's thoughtful attention and provide a forum for holistic assessment and pro-active response. But executing it is more complex, not only because of the commitment it requires, but because the details matter. With this in mind, and based on our experience with the strengths and limitations of other models we have worked around, we offer the following core suggestions for HPD to potentially build upon.

The Board is not primarily a disciplining body: It is true that recommending an administrative investigation into potential violations of policy could be one byproduct of the Board's review. However, its core function should be the broader scrutiny of critical incidents with an eye toward enhancing future operations as needed.

There should be something at stake: The Board should have the authority to request further information, recommend policy or procedure changes, refer an incident for an internal affairs investigation, review personnel records and make recommendations directly to the Chief for non-punitive remediation training, briefings, counseling, a supervised work plan, or other remedial measures.

***The candid input of all members should be expected, encouraged, and facilitated*:** The Board should have voting members and advisory members. It is advisable for the Chair to speak last and otherwise encourage frank uninhibited expression of points of view. The Board is much more meaningful if it draws upon the cumulative – and presumably varied – experience of those in the room, without excessive deference based on rank.

Inclusion should be a priority: Encouraging candor must be accompanied by inclusion of disparate points of view. A spectrum of advisors should sit on the board to make sure that different perspectives are considered. Examples could include a field sergeant, a representative of the HPOA, a non-sworn civilian employee of HPD or the

---

policy authorized the Chief to determine the composition of the FRB but did not designate its members. HPD's most recently revised Post-Force policy states that the FRB will be made up of a "peer, HPOA, training and supervisor decided upon by the Chief and will be assembled based on the unique nature and scope of the incident." (See HPD's Post Force Response Process and Reporting Policy 302, May 20, 2021).

City, in recognition of the City government's ultimate risk management and political responsibility for how the city's police force performs.

***The Board's purview should be wide*:** As a concentrated assembly of HPD's expertise and experience, the Board should be allowed to look beyond the moment that force was used. Legitimate concerns of a force review board include all lessons that can be derived from systems failures or successes surrounding critical incidents.

The wide purview principle also applies to whose actions and judgments are considered. Since all personnel on a shift should support and assist each other, subjects such as dispatch and inter-officer communications, supervisor decisions, team take-downs, evidence collection, and actions and reports of witness officers should be considered if they present issues.

The Board's findings and accomplishments should be considered on a periodic and collective basis: By carefully scrutinizing a steady stream of significant incidents and utilizing the best expertise within HPD, the Board will gain a perspective that no single individual in the department has. The Board should compile its quantifiable observations and policy recommendations and report them to the Chief and in some form to the public. A quarterly evaluation and reporting cycle could be further enhanced by the quarterly compilation report from the Department's risk manager.

***The Board's findings and conclusions should be translated into action items, with accountability for follow-through and closure*:** Too often, the good observations and prospective interventions that emerge from review end up "falling through the cracks" as agencies become preoccupied with the press of other business. The Board should create structures to prevent this from happening, including the designation of a specific party to be responsible for documenting the discussion and findings. Moreover, the Chair should devise a mechanism for assigning "action items" to specific Board members and ensuring timely completion of those tasks.

Creating a Force Review Board

In seeking to give concrete supports to some of the above-listed conceptual observations, we offer the following "roadmap" for design and implementation of a new Force Review Board model. Each of these steps comprise a part of numbered Recommendation # 34, in keeping with our sequencing:

RECOMMENDATION 34 a. HPD should prepare a guideline document concerning the make-up and purview of the Force Review Board and its procedures.

Purview – The Board may consider any aspect of an incident relevant to improving field operations, increasing the skill levels and understanding of employees, reducing use of force and injury, improving supervisor understanding of what transpires in the field, and increasing community confidence in the Department. These include but are not limited to:

- Field communications and decision making by officers and supervisors
- Whether relevant training was followed
- Choice and operation of weapons, restraint devices, shields and other equipment
- Post force obligations such as timely medical attention, evidence preservation, and witness identification
- De-escalation opportunities
- Effective communication with involved or uninvolved civilians
- Quality of incident reports and After Action reports

Presentations – Case presentations should be neutral and focused on the facts of the event in question. They should include any audio, video or photographic evidence essential to a clear understanding of the incident. Presenters should make the Board aware of any Professional Standards investigations, claims, lawsuits or public complaints that relate to the case presented.

Action Items – The Review Board should have a formal process to document, monitor and implement recommendations and action steps arising from the Board's discussions. As part of the process, the Chair should designate a Review Board member to debrief the involved officer(s), witness officers, and any on-scene supervisors regarding all issues identified by the Review Board.

RECOMMENDATION 34 b. HPD should define the range of cases that merit Board scrutiny, establishing clear thresholds but reserving the right

to allow for exceptions in the interest of flexibility and maximal benefit from the process.

RECOMMENDATION 34 c. HPD should ensure that the Chair is responsible for assigning documentation of the discussion and issue identification to a Board attendee.

RECOMMENDATION 34 d. HPD should ensure that the Chair is responsible for assigning any action items to Board members and designing a process to ensure timely completion and report back on assigned tasks.

RECOMMENDATION 34 e. HPD should ensure that the Chair is responsible for assigning a Board member to debrief involved and witness officers as well as any on-scene supervisors regarding issues identified during the Review Board process and documentation of any debriefing session.

There is no set definition of a “critical incident” that would merit Board scrutiny. We suggest

- any occasion where a police officer discharges a firearm on duty, whether there is an injury or not,
- any police action that requires hospital admission other than for mental health observation
- any police action that requires medical treatment of any injury other than superficial abrasions or bruises.

We also suggest that any supervisor of Lieutenant rank or above who feels that extenuating or complicating circumstances qualify the incident, regardless of its nature or level of injury, for Force Review, may refer it to the Board.

RECOMMENDATION 34 f. The Board’s composition should be as follows:

- A command staff member to sit as the Board Chair.

- Two other command staff level members who, with the Chair will constitute the voting members of the Board for purposes of findings, referrals and recommendations. All other members are advisory.

- A presenter of the facts of the case using body worn camera footage, radio and dispatch communications, photographs, maps, and other visual aids.

- An administrator to assist the Chair, prepare agendas, schedule meetings, prepare a summary of the discussion, issues identified, action plans, and track follow-up tasks as needed.

- Individual representatives from Training, Professional Standards, and the HPOA.

- Any subject matter expert not covered by the above members and relevant to the facts of the incident.

- The Department's risk manager.

RECOMMENDATION 34 g. The Board's meeting format should include the following components:

- Case files should be distributed to Board members well before meetings.

- The Board should discuss the case across an established set of topic areas, including issues of policy and procedure, tactics, supervision, communication and coordination, de-escalation, equipment, medical interventions (if relevant), investigative protocols, and other.

RECOMMENDATION 34 h. The Board should track cumulative trends and issue periodic reports or other interventions as needed with regard to individual officer performance issues or larger phenomena.

Section Four: Addressing Public and Administrative Complaints

Public Complaints

A police agency's public complaint process provides another important measure of accountability. The agency's responsiveness to allegations of officer misconduct made by members of the public is one hallmark of its effectiveness and community standing.

For this report, we reviewed the investigations of 4 complaints made by members of the public from 2018 to 2020.[28] Our overall assessment of HPD's process for addressing public complaints is positive. We offer recommendations for improvement based on the handful of examples we surveyed.

The Department provides information about filing a complaint on its website. Under a heading "Anonymous Complaints" the website states that HPD accepts complaints alleging biased policing online, by phone, in writing, via facsimile or email, in person or through a third party. It includes a link to an online form and states forms can also be obtained at HPD's Main Police Station.

This information is a positive component of HPD's complaint system. However, describing its complaint process as being limited to "complaints alleging biased policing" is likely inadvertent though problematic, suggesting that HPD accepts only complaints alleging that an officer was biased against an individual.[29] OIR Group suggests that HPD's website and complaint forms explain the range of police misconduct HPD investigates and include more information about the complaint process (such as interviewing the complainant, conducting an investigation and notifying the complainant of the investigation's conclusion). This information enables the public to better

---

[28] HPD received 18 public complaints in 2018, 38 public complaints in 2019 and 48 public complaints in 2020. The OIR Group was provided investigations from four public complaints to review.

[29] Oregon law prohibits police profiling (defined as targeting an individual based solely on the individual's real or perceived age, race, ethnicity, color, national origin, language, sex, gender identity, sexual orientation, political affiliation, religion, homelessness or disability) and requires law enforcement agencies to accept and investigate profiling complaints. (See ORS 131.920).

understand the steps HPD takes during the complaint process and the seriousness with which HPD treats public complaints of police misconduct.

The files we reviewed included thorough, timely investigations that were well documented. The files typically included a detailed report from the Office of Professional Standards ("OPS") investigator that summarized the complaint, its allegations and the evidence of the case obtained during the investigation.

Concerning a complaint involving a criminal investigation of child abuse, within a week of being interviewed by HPD's OPS investigator, the involved officer resigned from the Department. As illustrated by this case, HPD's authority and willingness to take prompt administrative action against officers alleged to be involved in criminal activity is vital to holding its officers to the high standards of both the Department and the community it serves.

In another case, the complainant alleged that while she awaited the issuance of a parking citation at a public parking lot, a non-sworn HPD employee told her to put her hands on the car and be "frisked." When she exclaimed alarm at his command, he told her, "That's fine, just get out of here." He did not issue her the citation and ended the interaction by walking away. The complainant was stunned and upset by the employee's behavior and filed a complaint with HPD shortly thereafter.

A month after receiving the complaint, the Department's OPS initiated its investigation. During OPS's interview of the non-sworn employee, he denied having any contact with the complainant and engaging in the alleged conduct. He volunteered that he sometimes jokes with members of the public.

OPS's Investigative Findings Report noted that the complainant was a long-time tenured county employee who had no motivation to lie; due to the individual's s conduct, she no longer parked at the public lot. The report also noted that the individual was a long-time HPD employee with no documented incidents or complaints similar to the alleged behavior. Stating it was difficult to prove by clear and compelling evidence that the individual engaged in the behavior described, the investigation concluded the policy violations were "not sustained." The non-sworn employee was issued a non-disciplinary counseling letter that summarized the complainant's account and the investigation's inability to prove or disprove the allegations and ordered him to be professional with the public and to read HPD's Harassment policy. HPD also sent the complainant a letter stating that the behaviors she had reported had been addressed on an administrative level with the employee.

The investigative report reflected thoughtful analysis of the evidence and the complainant's and non-sworn employee's credibility. However, we noted that the report

referred to “clear and compelling evidence” to support a not sustained finding rather than citing “preponderance of the evidence,” which is the commonly accepted standard for administrative investigations. We recommend that HPD update its Complaints and Investigations protocol to require “preponderance of the evidence” for administrative investigations and allow for definitive resolution in more cases.

This case is also noteworthy because HPD later received another complaint against this non-sworn employee alleging similar behavior. To HPD’s credit, when it recognized the potential criminal nature of the employee’s conduct and requested that an outside law enforcement agency conduct a criminal investigation, HPD included the earlier investigative file concerning the above-discussed complaint. This employee resigned while an HPD internal affairs investigation was pending and he was subsequently charged criminally by the District Attorney.

Another complaint concerned a police officer’s interaction with hospital staff after the hospital had called 911 to locate the arresting officer when they received a patient handcuffed to a gurney unaccompanied by the arresting officer. When the officer arrived and hospital staff asked him where he had been, he became defensive, yelled and reportedly told staff not to tell him how to do his job. OPS interviews of hospital staff indicated they were afraid during the encounter. Another HPD officer at the hospital who witnessed the interaction reported that the officer was not professional.

Both the investigation and the investigative report appeared thorough and detailed. It also included as background several other incidents involving the same officer engaging in problematic behavior. While a low level discipline was ultimately issued in this case, we had concern that in light of the investigative interviews, the actual notice of discipline minimized the officer’s role in the incident. Moreover, the investigation and notice of discipline never addressed the hospital’s original concern that initiated their 911 call to locate the arresting officer—the risk of sending an arrestee handcuffed to a gurney to the hospital without the arrestee being accompanied by an HPD officer.[30]

> RECOMMENDATION 35: HPD’s website and complaint forms should explain the range of police misconduct HPD investigates and include more information about the complaint process such as interviewing the complainant, conducting an investigation and notifying the complainant of the investigation’s conclusion.

[30] The officer had stayed at the arrest scene to deal with towing issues but was apparently in a position to either delegate that responsibility or have another officer do the hospital escort. BWC footage established the presence of several other HPD officers at the arrest scene.

RECOMMENDATION 36: HPD's policy should be changed so that all HPD's administrative investigations use a preponderance of the evidence standard in determining whether policies have been violated.

Administrative Complaints & Investigations

Because of the unique powers conferred upon the police by the state, administrative investigations – that is, examination of the actions of police personnel to determine whether they comply with the policies of the agency, also known as internal affairs investigations – are a vital function of any fully formed law enforcement agency. We reviewed 17 of HPD's 84 investigations of administrative complaints for the years 2018, 2019, and 2020. These cases delved into alleged policy violations by both sworn officers and non-sworn professional staff and provided a window into some of the significant challenges to managing a law enforcement agency. We describe below the range of cases we encountered, the quality of the investigation methodology employed by Professional Standards, and the degree to which HPD leadership succeeded in converting these problems into opportunities or lessons learned.

An internal affairs unit within a law enforcement agency performs a vital function contributing to the integrity of the agency and assisting with its progress as a learning organization. It must also achieve a basic level of trust among the agency's employees while exercising the impartiality the public expects. Simply put, a law enforcement agency determined to maintain high standards of performance and hold the trust of the community it serves must have a robust internal affairs unit with high standards of thoroughness and fairness. Based on its investigations and reports during the years under scrutiny for this report, the HPD internal affairs investigations met this high standard.

We found the seventeen investigations we assessed spanning 2018, 2019, and 2020 to be generally high quality, thorough and logical. For the most part, they commenced within a few days or weeks after discovery of the circumstances that led to the allegation and proceeded rapidly from there. Most investigations wrapped up within a month or two. Subjects were kept informed of the commencement and conclusion of the investigations – a step that many agencies neglect, and that shows a proper regard for the effect of pending cases on employees. Ample witnesses were interviewed. This was true even where the stakes were fairly low; that is, when the maximum discipline that could result from a "sustained" finding was very unlikely to be termination, demotion, or lengthy suspension. The evaluation of the evidence by decision makers

was well documented and well-reasoned, and their application of the Department's policies was appropriate.

At HPD, administrative investigators do not make recommendations as to disposition of the allegations. While the investigators may express opinions about some things such as apparent truthfulness, the system leaves the final determinations to persons in the subject's chain of command at the Commander level and above.

When it comes to applying discipline, Department decision-makers refer to principles of proportionality and progressive discipline but often err on the side of leniency. Additionally, it appeared that an officer's personnel history is often reviewed narrowly for allegations similar to the current case instead of looking at patterns of escalating or problematic behavior.

Department decision-makers frequently draw on a Department Training asset to address performance problems – that is, tailored training modules for individual officers who misuse force options, misunderstand policy or who struggle with executing a particular force technique, whether the force was deemed out of policy or not. This strikes us as a constructive response to problems that arise from performance shortcomings rather than malicious intent. But the remedial training option, for all its strengths and its relative palatability to employees, is not a sufficient response for every violation. Depending on the behavior at issue, further accountability measures are sometimes needed, and HPD should refrain from defaulting to training too readily.

One officer was the subject of several administrative investigations during the three-year window that we examined. In 2018, he received remedial training following two different force incident investigations. He also received counseling and remedial training on vehicle pursuits after an out-of-policy pursuit. Unfortunately, though, problematic behavior continued – as did the agency's relatively limited efforts at intervention.

- The next year, he assisted in a domestic violence response when a fellow officer was in the process of handcuffing a compliant female subject who was yelling that she did not trust the assisting officer because of his race. The officer moved toward the subject and pushed her head and escalated the incident, thwarting the handcuffing. The officer received a written reprimand plus remedial training in de-escalation.

- That year too, the officer assisted two other officers with the arrest of a theft subject outside a store. After the subject threw his wallet to the ground when asked for identification, the subject pulled away from the officer and began to walk away. The officer reached out with an open hand and pushed the subject's head into a wall mounted fiberglass community mailbox then fired his Taser at

the subject's back. He later described this as a "distraction blow." A Commander, now retired, determined that the head strike was out of policy and the Taser use was within policy but disappointingly did not refer the case to the Office of Professional Standards for an administrative investigation. The Commander recommended remedial training.

- A few months later, the officer assisted an arrest of an extremely intoxicated and verbally belligerent subject who ended up arrested on a charge of "menacing." The lieutenant who reviewed the BWC footage had trouble discerning any menacing behavior by the arrestee. The allegation of arrest without probable cause was not sustained, but another allegation was sustained against the officer for failure to complete incident reports and to comply with sick leave rules.

- In 2020, the officer arrested an elderly drunk driving subject and transported him to jail. During the booking process, when the arrestee would not stop complaining and paced the booking area, the officer stood up from his desk, pushed him down on the bench and, when the arrestee put both hands on the officer's wrist, the officer grabbed the arrestee by the collar, punched him twice in the head and took him to the floor. Almost two years after the incident, and after initiation of a civil suit by the arrestee, the officer received low level discipline and remedial training.

This pattern of questionable decisions and actions in the field, often followed by remedial training or the most lenient of disciplinary actions appears to show a reluctance to use the disciplinary system to full effect. Most of the officer's uses of force that were questioned by supervisors had an important element in common – an impulsive physical response to verbal abuse from an arrestee. This suggests a problem controlling anger under circumstances to which officers are routinely subjected in the field.

If HPD's leaders recognize that some officers may not be handling common challenges of patrol work in accord with Department expectations, this has obvious implications that merit intervention. Officers who are sometimes ruled by impulse in the field are a potential threat to subjects and witnesses as well as to the good order of the agency. Department leadership has a responsibility to use the tools available to them to mitigate these dangers. Discipline is necessarily one of these tools and can be an effective deterrent. Additionally, an appropriately graduated series of consequences can provide the foundation for separating officers from the agency if that becomes necessary. And the discipline process is a form of messaging about Department standards and expectations that has resonance for the agency as a whole.

While remedial training certainly has *potential* relevance in a context like this, it is also incumbent on the agency to determine whether it is working. Sometimes the officer's issues may transcend the suitability of training as an intervention. If so, the Department should not keep turning to it in lieu of a sterner – and ideally more impactful – consequence.

Another important tool that should also be considered is a supervised "work plan." Work plans involve assigning a supervisor/mentor to establish performance goals and benchmarks, then closely track the subject employee's performance and meet frequently with the subject to discuss problems and reinforce the Department's standards. Put bluntly, the objective of a work plan is to save the employee's career. This can be a constructive formula for diverting an officer from repeated mistakes toward a viable future with the agency. It is surprising that, while HPD has procedures for placing an employee on a work plan, it never tried one with this officer.

> RECOMMENDATION 37: A supervisor should consider a subject employee's failure to mitigate past misconduct after receiving counseling and/or retraining, an aggravating factor when similar misconduct occurs again.
>
> RECOMMENDATION 38: Supervisors of an officer who manifests a pattern of force that does not comport with the Department's ideals should strongly consider placing the officer on a closely supervised work plan.
>
> RECOMMENDATION 39: HPD should revise its policy to require referral to an administrative investigation in cases where there are indicia of excessive or unnecessary force.

The cases above, while exceptional in some respects, followed a general pattern of cautious application of discipline. Following the administrative investigations that we reviewed, the imposition of a level of discipline above a written reprimand was very rare.

Importantly, we did observe a notable exception to this apparent tendency toward lenient application of discipline. A case involving allegations of sexual harassment led to the demotion of the subject officer. The decision-maker's resort to that severe consequence, however, was explicitly grounded on the facts that the subject was a supervisor in the Department, had already received the benefit of much less severe discipline (in keeping with the principle of graduated or "progressive" discipline) , and, while the objectionable behavior was off duty, he had met the non-employee victim while on duty. He had focused a stream of unwanted attention through many internet communications sent to the victim over a two-day period commenting on her body, asking about her taste in clothing and appearing to suggest an intimate relationship.

Even this relatively stern outcome had a concerning element, though: it followed on the heels of a similar past incident of inappropriate and sexually charged statements for which the subject had received only a written reprimand. While attending a training seminar, he had tried to engage a member of the Department in inappropriate intimate conversation and appeared to suggest an inappropriate intimate relationship. That the Department's response to that case had been so tepid seems all the more unfortunate in light of the behavior's recurrence.

Another incident, prominent among those we reviewed, involved an anonymous critical and cruel letter that had been left for a sworn employee. The letter accused the staff member of being a whistle blower disloyal to her colleagues and made biased comments about race and gender. The Department, perhaps recognizing the sensitivity of the issues raised by the incident as well as the need to interview many other employees in the search for the anonymous letter-writer, prudently chose to engage an outside investigator. This unusual step was both astute and appropriate given the circumstances of the allegations. However, this investigation appears to have suffered from insufficient direction at the onset from HPD. To address the need for engaging an outside investigator in the future, OIR recommends that HPD implement a written policy that includes the circumstances requiring an outside investigator, the selection process, and defines the investigator's duties and scope of the investigation.

> RECOMMENDATION 40: HPD should develop policy for engaging an outside investigator during an administrative investigation that sets forth the circumstances requiring an outside investigator, the selection process and establishes the investigator's duties and scope of the investigation for the incident.

Section Five: Other Accountability Issues

Strategies for Addressing Lawsuits Against HPD

HPD has grappled with several costly lawsuits in recent years. We view litigation as a "complaint with a price tag" – a potential source of liability, to be sure, but also an opportunity to assess someone's claim of harm for purposes of internal improvement as needed. Accordingly, the best systems for responding in such cases will take a comprehensive, proactive approach to the potential misconduct and operational issues that are presented.

We did not review specific lawsuits brought against HPD and do not comment on the merits of those lawsuits or the reasoning behind those settlements. Nonetheless, at least one of the cases involved an officer-involved shooting. Our previously discussed observations and recommendations to enhance HPD's administrative investigation and review of officer-involved shootings and other critical incidents will provide the Department more tools to promptly identify and address individual performance as well as systemic issues.

From our discussions with HPD staff, it appears that the Department is regularly notified of civil claims and has an effective process for responding to document requests. HPD executive staff includes a risk manager who plays an important role in liaising with the city's risk manager, the city attorney's office and claims adjuster.

We suggest that HPD develop written protocols to address certain aspects of civil litigation claims. For example, HPD should have a process for reviewing a claim and determining whether it merits an administrative investigation if HPD has not already initiated an investigation.

Additionally, some civil claims will present an inherent conflict of interest for HPD to conduct its own investigation into these allegations. (One example would be an allegation by an employee of a discriminatory promotional process.) While there may be compelling reasons for HPD to also conduct an investigation, when a conflict of interest exists, it is imperative that an independent, third party conduct an investigation and that HPD have a protocol in place that identifies and addresses conflicts of interest.

Whenever allegations of police misconduct are raised through the vehicle of civil litigation, the resulting investigation must address a range of components to be effective. The fact-gathering should ideally assess violations of law and policy – and examine whether there was insufficient guidance through policy or training that led to performance issues. It is vital for the police agency to address every allegation and collect sufficient facts to make informed decisions about accountability, systemic reform and risk management. The resulting evidence should also provide those defending the lawsuit with a means to better evaluate litigative risk. More broadly, a comprehensive investigation should serve as a basis for issue-spotting that can guide Police Department leadership toward necessary interventions in a timely manner.

HPD staff discussed having periodic meetings for status updates on litigation claims. This sound practice could also be enhanced by assigning a supervisor or someone from its Office of Professional Standards to attend depositions or review transcripts of civil litigation interviews for purposes of accountability issue-spotting.

Additionally, while HPD may be informed of the outcome of civil lawsuits, it does not appear that HPD and its city partners engage in a formal After Action process that includes written recommendations and action steps to address performance or operational issues within HPD identified from the litigation process. We recognize that a variety of factors can shape the course of civil litigation, and not all of them translate directly into productive bases for change. But there is inherent value in giving thoughtful consideration to the lessons that such outcomes have to offer.

RECOMMENDATION 41: HPD should develop written protocols concerning civil litigation claims that includes a process for determining whether HPD is conducting its own internal investigation and whether an outside investigator should also be conducting an investigation.

RECOMMENDATION 42: HPD should develop written protocols to ensure that internal investigations initiated in response to lawsuits or claims address and thoroughly investigate each allegation raised by the complainant.

RECOMMENDATION 43: HPD should assign a supervisor to review information developed during litigation, with a focus on learning of and responding to any performance and operational issues that may emerge in the litigation process.

RECOMMENDATION 44: HPD should continue monitoring the status of civil litigation claims through periodic meetings that also provide updates about any performance and operational issues that emerge during the litigation process.

RECOMMENDATION 45: Prior to any settlement or following any adverse judgment in civil litigation, HPD should develop an After Action plan that shows its response to identified performance issues and ensures that responsive adjustments will occur when applicable.

Early Intervention System

Many police agencies have recognized the benefit of developing an early identification system (EIS) regarding uses of force and complaints and investigations of force. Such a system can allow for early, positive intervention with those officers who may be using more force than strictly necessary, and can allow for implementation of remedial measures such as training, debriefing, and mentoring. Law enforcement agencies have

other information streams that can be fed into an effective early intervention system. Non-force-related misconduct, episodes of poor communication or episodes of anger, traffic collisions, or absenteeism might all correlate with a police career in jeopardy.

The importance of a computer-based system for flagging such profiles as they emerge is perhaps greater in a larger agency. An industry leader in the concept was the Los Angeles County Sheriff's Department, which has several thousand sworn officers. However, there is absolutely applicability to such pro-active attention in smaller agencies as well – and can be easier to accomplish.

The objective of an EIS should be non-punitive—to identify and rehabilitate a spectrum of problems in order to redirect an employee's trajectory and give him or her the tools to live up to the Department's standards. Tools such as mentorships with experienced supervisors or peer employees, training in interpersonal skills as well as more conventional police skills can be used to intervene before issues turn into significant misconduct and more drastic consequences become necessary.

The internal report management system – called "Blue Team" – that HPD uses contains some capabilities to function as an early warning/early intervention system, but we are informed that the Department has not activated those features.

> RECOMMENDATION 46: The Department should develop an early identification system that allows for timely, positive intervention as needed for officers who exhibit a high frequency of risk-related encounters or other performance deficiencies.

Public Reporting on Use of Force and Complaint Data

The Department currently provides some use of force and complaint data on its website. Annually, the Department issues a Use of Force summary that identifies the types of force throughout the year, reasons for force and some demographics of those subjected to force. The Department also issues an annual Summary of Complaints that explains the Department's complaint investigative process and identifies the types of public and administrative complaints it received throughout the year. It also provides aggregate information about the disposition of complaints.

We suggest enhancing these reports by providing more detailed information and analysis of this data, including any Department responses to trends or patterns the Department has identified. For example, the Department's Blue Team platform has great potential for providing data on the overall use of force broken down by types of

force used, locations, dates and times, and the demographics of both officers and subjects. We recommend that the Department use this information to identify not only trends and potential systemic issues for its own internal purposes but also for discussion in its annual use of force reports. The Department's annual Summary of Complaint reports could also be strengthened by providing more information about the demographics of complainants (age, race/ethnicity, gender, primary language) and complaint summaries (while protecting officer privacy rights).

> RECOMMENDATION 47: The Department should publicly post more of its use of force and complaint data on its website and consider enhancing its annual reports to include analysis of this data and any changes in training, equipment or tactics the Department has initiated in response to its analysis.

Conclusion

A common quality in high-functioning organizations is a commitment to ongoing reform efforts. Shifting priorities, evolving public expectations, new societal trends, and watershed incidents all contribute to the near-constant need for adaptation – and each of these influences pertain directly to law enforcement agencies throughout the country. But beyond this baseline reality, we are living through a period of unprecedented focus on policing. Longstanding "default" premises are being revisited in fundamental ways, and the attendant disruptions are giving the process of reform new prominence and urgency.

Against this backdrop, police departments – and individual officers – are reacting variously. An undercurrent of defensiveness or even resentment is a prominent feature of these reactions, and at least some of that sentiment has legitimacy. It is important to recognize that "broad-brush" criticisms and hastily, unilaterally imposed changes have the potential to be counterproductive.

Nonetheless, it seems undeniable that a transition to new models and new ways of thinking has been galvanized by recent events. And the agencies that recognize the phenomenon and attempt to accept it as a challenge *and* an opportunity are likely to be the ones that emerge with the most workable new paradigms and healthiest relationship with their communities.

In our experience with the Hillsboro Police Department and its systems for internal review, we see encouraging ingredients that can allow the agency to succeed in this

new environment. We reiterate the favorable impression that arose from the very act of initiating an outside review, and that was then reinforced by the cooperation and thoughtfulness of the individual Department members with whom we interacted. Receptivity matters.

Beyond that, and as discussed above, the agency's existing mechanisms for internal review showed promise and often delivered meaningful examples of rigor, objectivity, and accountability. As reflected in our recommendations, the shortcomings that we did identify lend themselves to attainable fixes – rather than arising from a dysfunctional or resistant culture. And, to the extent that some of the Department's structures for review could themselves benefit from enhancement, we believe that the new approaches we offer above will facilitate a more comprehensive and valuable set of processes.

Increased transparency and greater public influence on police operations are certainly components of the aforementioned trends that are sweeping over the country's law enforcement agencies. But an agency's ability to address its own performance, grapple with its own issues, and make its own effective adjustments is more critical than ever. We intend this report as a springboard for HPD to strengthen those abilities, and we wish the Department well in its efforts to do so.

Appendix of Recommendations

1: The Department should revise its policies to require that its administrative investigation of shootings and other critical incidents commence immediately by appointing HPD personnel to participate in the walk-through of the crime scene, observe MCT's witness and involved officer interviews and actively monitor the ongoing criminal investigation.

2: The Department should propose that MCT procedures include interviews of involved and witness officers before the end of their shift unless extenuating circumstances such as injury of an officer preclude this.

3: The Department should revise its policies to require administrative interviews of involved and witness personnel to address not only whether the involved officer(s)' actions complied with policy and training but also to examine areas such as planning, tactics, coordination, de-escalation, communication, force option choices, supervision, equipment and post-shooting conduct.

4: The Department should revise its policies to provide a timeline, scope and process for conducting the administrative investigation, findings, and written report of officer-involved shootings and other critical incidents.

5: The Department should revise its review protocols to incorporate time-appropriate phases, beginning with an early, initial debriefing of Department leadership, continuing to a more thorough examination of administrative issues including officer performance, and culminating in a formal Review Board for officer- involved shootings and other critical incidents.

6: The Department should revise policies to require video recording of its administrative interviews of involved and witness officers and civilians in officer-involved shootings and other critical incidents.

7: The Department should reformulate its "Firearm Discharge" policy as a Critical Incident policy that includes comprehensive assessment of a wider range of "high risk" encounters, such as non-hit shootings, in-custody deaths, and non-fatal critical incidents such as vehicle pursuits that result in injury, force incidents that result in hospitalization or other incidents that garner media attention and/or create a substantial risk.

8: The Department should include in its Critical Incident policy a Review Board that is convened at the conclusion of the administrative investigation to evaluate the entire incident and make recommendations. The Board's composition, duties, timelines, meetings and scope should be defined in this policy or elsewhere.

9: The Department should include in its Critical Incident policy a provision that involved and witness officers be debriefed on any issues/concerns identified by the Review Board.

10: The Department should provide training consistent with its newly revised Use of Force policy to address officer and supervisor duties when force has been used on a subject including requesting medical assistance, providing life-saving measures, monitoring the subject, and notifying medical assistance as to the force used and the circumstance.

11: HPD should modify its Use of Force policies to define reportable use of force.

12: HPD should modify its Use of Force policies to define "show of force" and any duties officers and supervisors have concerning the reporting, documentation and review of show of force conduct.

13: Supervisors and subsequent reviewers in the chain of command should consider and analyze the efficacy and appropriateness of all uses of force within the incident.

14: The Department should provide further guidance to its officers by prohibiting distraction strikes to the head and other sensitive areas, requiring delivery of such strikes with the palm, and limiting the number of distraction strikes.

15: HPD procedural guidelines should state that After Action Reports must be completed within a week of the incident in question, barring special circumstances, with extensions requiring supervisory approval.

16: HPD policy should be revised to require non-involved supervisors to review force incidents and draft After Action Reports.

17: HPD should devise policy and appropriate training instructing sergeants to avoid becoming involved in uses of force unless their active participation is necessary and instead directing them to assume a supervisory role over the incident.

18: Supervisors and subsequent reviewers writing After Action Reports should consider the threshold question of why an action was taken and whether there were preferable alternatives that could reasonably have been considered.

19: After Action Reports should evaluate the actions and decision-making of force users as well as supervisors or others involved in the incident in any manner relevant to the use of force.

20: The Department should require analysis of any other failures to comply with law or policy that arise in the course of a use of force investigation.

21: The Department should revise its BWC policy to advise its officers to activate both video and audio features when dealing with the public except in narrowly specified exceptions.

22: The Department should revise its BWC policy to require officers to review footage when preparing an incident report in support of an arrest or citation but to refrain from review in cases in which the officers' conduct is at issue (such as a use of force, complaint, or internal affairs investigation) until a pure initial statement can be obtained.

23: The Department should quantify the effectiveness of any initiatives it takes to mitigate targeted problems such as mental health crisis responses, including deployment of special equipment, techniques or personnel, by establishing a baseline of relevant statistics, then periodically compiling measurements of any changes.

24: Field supervisors and subsequent reviewers should ensure that all aspects of HPD's current policy and training are considered in evaluating Taser deployments.

25: The Department should revise its canine policy to require that K-9 officers include the factual basis for arrest for subjects against whom a canine is deployed.

26: The Department should develop policy accompanied by supervisor training to ensure a holistic review of canine incidents that includes the performance of all involved personnel (not just K-9 handlers) as well as issues of planning, tactics coordination, de-escalation, force option choices, communication, supervision, equipment, training, policy and post-incident conduct.

27: The Department's review of canine deployment should include an evaluation of what steps, if any, could have been taken to minimize the duration and number of canine bites.

28: The Department should require that its Use of Force files include documents and police reports from outside agencies that are involved or have relevant information about the Department's use of force incident.

29: The Department should require that subject charges and their status be included in the Department's Use of Force file.

30: The Department should require that the implementation of After Action Closure Recommendations be documented in a closure memo that describes the remedial training, policy change or action taken and kept in the Use of Force file.

31: The Department should require that canine deployments involving injuries be reviewed by a Use of Force Board.

32: The Department should regularly collect and review canine data to identify trends and promptly investigate outlying numbers.

33: The Department should regularly publish its canine usage statistics on its website and as part of its Use of Force Annual Report.

34: a. HPD should prepare a guideline document concerning the make-up and purview of the Force Review Board and its procedures.

b. HPD should define the range of cases that merit Board scrutiny, establishing clear thresholds but reserving the right to allow for exceptions in the interest of flexibility and maximal benefit from the process.

c. HPD should ensure that the Chair is responsible for assigning documentation of the discussion and issue identification to a Board attendee.

d. HPD should ensure that the Chair is responsible for assigning any action items to Board members and designing a process to ensure timely completion and report back on assigned tasks.

e. HPD should ensure that the Chair is responsible for assigning a Board member to debrief involved and witness officers as well as any on-scene supervisors regarding issues identified during the Review Board process and documentation of any debriefing session.

f. The Board's composition should be as follows:

- A command staff member to sit as the Board Chair.
- Two other command staff level members who, with the Chair will constitute the voting members of the Board for purposes of findings, referrals and recommendations. All other members are advisory.

- A presenter of the facts of the case using body worn camera footage, radio and dispatch communications, photographs, maps, and other visual aids.

- An administrator to assist the Chair, prepare agendas, schedule meetings, prepare a summary of the discussion, issues identified, action plans, and track follow-up tasks as needed.

- Individual representatives from Training, Professional Standards, and the HPOA.

- Any subject matter expert not covered by the above members and relevant to the facts of the incident.

- The Department's risk manager.

g. The Board's meeting format should include the following components:

- Case files should be distributed to Board members well before meetings.

- The Board should discuss the case across an established set of topic areas, including issues of policy and procedure, tactics, supervision, communication and coordination, de-escalation, equipment, medical interventions (if relevant), investigative protocols, and other.

h. The Board should track cumulative trends and issue periodic reports or other interventions as needed with regard to individual officer performance issues or larger phenomena.

35: HPD's website and complaint forms should explain the range of police misconduct HPD investigates and include more information about the complaint process such as interviewing the complainant, conducting an investigation and notifying the complainant of the investigation's conclusion.

36: HPD's policy should be changed so that all HPD's administrative investigations use a preponderance of the evidence standard in determining whether policies have been violated.

37: A supervisor should consider a subject employee's failure to mitigate past misconduct after receiving counseling and/or retraining, an aggravating factor when similar misconduct occurs again.

38: Supervisors of an officer who manifests a pattern of force that does not comport with the Department's ideals should strongly consider placing the officer on a closely supervised work plan.

39: HPD should revise its policy to require referral to an administrative investigation in cases where there are indicia of excessive or unnecessary force.

40: HPD should develop policy for engaging an outside investigator during an administrative investigation that sets forth the circumstances requiring an outside investigator, the selection process and establishes the investigator's duties and scope of the investigation for the incident.

41: HPD should develop written protocols concerning civil litigation claims that includes a process for determining whether HPD is conducting its own internal investigation and whether an outside investigator should also be conducting an investigation.

42: HPD should develop written protocols to ensure that internal investigations initiated in response to lawsuits or claims address and thoroughly investigate each allegation raised by the complainant.

43: HPD should assign a supervisor to review information developed during litigation, with a focus on learning of and responding to any performance and operational issues that may emerge in the litigation process.

44: HPD should continue monitoring the status of civil litigation claims through periodic meetings that also provide updates about any performance and operational issues that emerge during the litigation process.

45: Prior to any settlement or following any adverse judgment in civil litigation, HPD should develop an After Action plan that shows its response to identified performance issues and ensures that responsive adjustments will occur when applicable.

46: The Department should develop an early identification system that allows for timely, positive intervention as needed for officers who exhibit a high frequency of risk-related encounters or other performance deficiencies.

47: The Department should publicly post more of its use of force and complaint data on its website and consider enhancing its annual report to include analysis of this data and any changes in training, equipment or tactics the Department has initiated in response to its analysis.