OIR
GROUP
1443 E. Washington Blvd., #234
Pasadena, California 91104
(310) 937-4009
Michael.gennaco@oirgroup.com

December 5, 2012

Earl F. Martin, Chair
City of Spokane
Use of Force Commission
c/o Gonzaga University
502 East Boone Avenue
Spokane, WA 99258

RE: OIR Group Review of Spokane Police Departments Use of Force Practices

Dear Mr. Martin:

I. Introduction

Pursuant to the 2012 Consultant Agreement with the City of Spokane, please consider this Report as OIR Group's review and assessment of the Spokane Police Department's ("SPD") use of force practices, policies and procedures. During our review, we evaluated a total of twelve force incidents, including canine deployments, two officer involved shootings and internal affairs investigations. Our goal was to examine how the Department reports the use of force and how force incidents are reviewed and to evaluate the quality of its administrative investigations. We would be remiss not to comment on the assistance provided to our review by the SPD command staff in helping us understand the protocols and procedures of the Department. That assistance was critical in providing us a baseline understanding of those processes and we are grateful for their time and cordiality.

Our comments fall into four main sections. In the first section, we discuss two shooting incidents and identify some potential room for improvement, as well as, notable effective practices within the SPD post-critical incident processes. With regard to the shootings, we reviewed the investigative and administrative processes of those incidents, as well as the work undertaken by the Deadly Force Review Board (DFRB), a body intended to review critical incidents to identify training, supervision, equipment and other systemic issues with a goal to identifying potential "lessons learned". In the next section, we conducted an "autopsy" of individual use of force cases and noted instances where gaps in the reporting practices and evidence gathering and a circumscribed approach to reviewing a use of force prevented the

Department from learning all it could about an incident or an officer's conduct. Next, we identify potential strengths and weaknesses of the internal affairs investigations. In the fourth section, we discuss other potential areas of reform of SPD policies and its use of force protocols and practices. In each section, we provide a list of recommendations that relate directly to the issues we identified in this report.

II. Officer -Involved Shooting Incidents

In our review, we assessed two officer-involved shootings. Consistent with a relatively newly devised protocol, the criminal investigations were conducted by a "Response Team" which includes detectives from the homicide units of the Spokane County Sheriff's Department and the Spokane Police Department, along with detectives assigned to the criminal investigative unit of the Washington State Patrol's Spokane District. Per those protocols, the lead investigator is not a member of the involved employee's agency. The criminal investigative reports were submitted to the local prosecutor for review and, in both instances, the shootings were deemed by the prosecutor to be legally justified. There was a subsequent administrative investigation conducted by SPD in one of the two shooting incidents we reviewed. We offer the following observations about the Department's post-incident response and review of the shooting incidents.

A. Date of incident: November 2010

In this officer-involved shooting, the subject arrived at a residence and yelled for his father to come out. According to witnesses, when the father did not come out, the subject threatened to kill his father and used a shotgun to shoot several rounds at the house. The subject then drove away. SPD received 911 calls from neighbors regarding the incident. A responding officer received information from witnesses about what had occurred and pointed out the subject's direction of travel.

Officer C then observed the subject's vehicle and informed dispatch of the subject's actions and location. The subject stopped and exited his vehicle with the shotgun in his hands and fled on foot in the direction of a restaurant. Officer C believed that the subject was attempting to enter the restaurant and fired a round at the subject. The subject diverted and was pursued on foot by Officer C who fired four more rounds at the subject.

Officer P also observed the subject with the shotgun in his hands and followed him on foot. Officer P saw two other officers pull into the area. Officer P fired two rounds at the subject. Corporal M saw the subject exit his vehicle with the shotgun and heard officers order the subject to drop his weapon. Corporal M then ordered the subject to drop his weapon and fired two rounds at the subject.

Officer H1 told investigators that he observed the subject fire his shotgun. However, it could not be established during the subsequent investigation whether, in fact, the subject had fired his weapon. Officer H1 fired five rounds at the subject.

Officer H2 and Officer S exited from their vehicle and ordered the subject to drop his weapon. The subject yelled back but refused to comply. Officer S fired two rounds at the subject and Officer H2 fired 12 rounds at the subject using an AR15 rifle. The subject then turned and fatally collapsed on the ground.

In accord with the above-described protocols, a joint criminal investigation headed by the Spokane Sheriff's Department was conducted and presented to the District Attorney who found the use of deadly force legally justified. Following a subsequent internal investigation, the SPD Administrative Review Panel found no violations of policy by the involved officers. Finally, a Deadly Force Review Board was convened and made certain recommendations described below.

Investigative Issues

Transparency: A redacted copy of the criminal investigation is available on-line. SPD is to be commended for making the investigation available for all to review. However, unlike the internal affairs investigations of force incidents, the internal affairs investigation of the shooting is not publicly available.

Organization: The criminal investigation that appears on-line is not well organized or easy to follow. There is no table of contents and the first scores of pages consist of supplemental reports by officers who responded to the scene but were not involved in the shooting. No summary of the incident appears until well into the hundreds of page of documents that comprise the investigative report.

Witness Canvass: To the investigative team's credit, there was an extensive and well-documented witness canvass of the incident.

Police Response: To the investigative team's credit, all responding officers documented their response and actions relating to the incident, however minimal.

First Names Used in Reports: As we have also noted in our review of other force incidents, the police reports repeatedly refer to the subject, involved police officers, and other civilian witnesses by their first names. The use of last names in the reports would instill in the investigation a more appropriate degree of formality.

Transport of Officers: The police reports indicate that the involved officers were individually transported away from the location. Transporting of involved officers individually is a best practice designed to preserve the integrity of the investigation and avoid contamination of observations and recall.

Apparent Lack of Segregation of Officers: While the transport of officers was consistent with best practices, at least one involved officer indicated that the location that officers were directed to at the station prior to being processed and interviewed was not ideal and created a potential for witness contamination. According to this officer, he was escorted to the station

lunch room, where individuals were discussing the shooting and secretaries were entering and leaving. The officer indicated he would have preferred being segregated from everyone else involved so that he could not have heard what others were saying about the incident. This issue expressly identified by at least one involved officer was not further explored by the investigation nor commented on by the DFRB.

Scene Contamination: One involved officer indicated that after the subject went down, he did not feel good about where the shotgun had come to rest and therefore moved the weapon farther away. A responding sergeant confirmed that this had occurred and that he had instructed the officer to put the shotgun back but it was not placed back in the original position in which it was found. This act by an SPD officer that disturbed the scene was not reviewed nor critiqued by the DFRB.

Diagrams: To SPD's credit, a high quality scaled diagram was prepared in the investigation. Unfortunately, the diagram was not regularly presented to witnesses during either the criminal or internal investigations. It would have been extremely helpful in understanding this dynamic complicated event had the involved officers been presented with a copy of the diagram in which they could have traced the paths that they took, their direction of fire, the location of the subject, etc. Instead, the involved officers were shown aerial photographs from Google maps or asked to construct their own diagrams to depict their path of movement.

Use of Waiver: Investigators assigned to help process the crime scene recognized that the Spokane Tribal Building had suffered bullet strikes as a result of the shooting and were interested in determining whether there was any further damage to the interior of the building. Appropriately, an individual who had regular access to the building was contacted and signed a waiver allowing investigators to enter the building. The use of the waiver was consistent with best practices so that investigators had certain legal authority to enter the building and further their investigation.

Leading Questions: During the internal investigation, there was repeated use of leading questions during the interviews of involved officers by the investigative team. Leading questions can be interpreted as not intended to objectively document the officer's recollection but rather helping guide the officer to provide an answer consistent with what the interviewer is seeking.

Examples of leading questions are frequent in the internal investigative reports:

Officer C was asked by a Spokane Internal Affairs investigator: "So you were concerned at all about, um, the situation turning into either an active shooter or hostage situation inside the restaurant?" to which he responded "Yes."

During Officer H2's interview, the Spokane Ombudsman[1] asked: "But you felt threatened by that action, is that correct?" The officer responded "Yes".

During Officer P's interview, he was asked by the Spokane Ombudsman: "So you felt that he posed an immediate threat to the public as well as to officers at the location?" to which the officer responded: "Absolutely."

Later Officer P was asked by the Spokane Ombudsman: "So the location where you took the shot then, if I understand it, would've posed the least likely threat to bystanders or onlookers or the public, is that correct?" to which the officer responded: "Correct, absolutely."

Officer S was asked by a Spokane Internal Affairs investigator: "Well, um, you stated before that you had concerns for the community, um, did you also have concerns for Officer [H2's] safety and your own safety?" to which the officer replied: "Yes."

Officer H1 was asked by a Spokane Internal Affairs investigator: "Okay, so I guess to paraphrase what you said, um, your use of deadly force was in defense of other officers on scene as well as the general public that was in the immediate area?" to which the officer replied in the affirmative.

Officer H2 was asked by the Ombudsman: "Okay, and I believe you said it, but I just wanted to affirm, he did actually point the shotgun at you several times, is that correct?" but the questioner did not get the anticipated response: "He… it wasn't directly at me. It was in the air and then when he started running to the west, it was pointed down towards the west, but he was looking back at me." The questioner then asked, "Okay, so… but you felt threatened by that action, is that correct?" to which the officer then replied "Yes… yes."

These leading questions which go to the heart of the reason for using deadly force or the officers' tactical decision-making can be perceived as directing the officers to answer the question in a way that would legally justify their use of force and could be interpreted that the interview is designed to elicit answers that do so. This practice is inconsistent with the goals of objective fact gathering which should be designed to obtain an account from the witness; not to potentially guide the witness to an account that the questioner presumes, expects or desires.

On a related subject, the involved officers were asked by a Spokane Internal Affairs investigator whether their actions were consistent with training. The utility of this question is subject, and not surprisingly, all of the officers responded to the question in the affirmative.

[1] Per current protocols, the Spokane Ombudsman participates in internal affairs interviews of involved officers.

Officers' On-Scene Cooperation/ Failure to Obtain Timely Statements from Two Involved Officers

All six of the officers provided brief "tactical" interviews primarily intended to guide detectives in their search for evidence. To their credit, four of the involved officers also provided voluntary interviews shortly after the incident. However, those interviews did not occur until three to five days after the incident. In accord with standard investigative practices and to gain the public's trust of officer-involved shooting investigations, it is critical to obtain detailed interviews of the officer's observations and actions close in time to the incident. While the impact of the delay in obtaining a detailed interview is ameliorated somewhat as a result of the "tactical" interviews that were conducted closer in time to the incident, the 3-5 day delay in obtaining detailed interviews with the involved officers is well short of ideal.

Even more concerning is how the investigation dealt with two officers who declined to provide detailed voluntary interviews. Those officers were not interviewed in depth about their observations and actions until approximately five months after the incident. That means that for five months, these officers were not required to provide a detailed version of what occurred. Interestingly, as a result, one officer was no longer able to recall some of the details of the incident with any specificity. That same officer raised a concern during the interview about the gap between the incident and the time in which he provided the interview and thought that the administrative interview should have occurred much closer in time to the incident so that he could have reached "closure" about the incident.

It is critical for any effective deadly force investigation that all involved officers as part of their job duties be required to provide detailed accounts of their observations and actions close in time to the incident. To cause officers to delay providing that account for months after the incident results in recollections that have faded and potentially contaminated by other information received in the intervening months. In fact, in this case, contamination was likely with regard to at least one of the officers who was not interviewed in detail until months later. At the time of his interview, he acknowledged that he had discussed the event in a group during a team debriefing approximately a week after the incident. While officers have the Constitutional right not to provide voluntary statements, it is incumbent upon SPD to obtain compelled administrative interviews from those officers who decline to provide voluntary statements close in time to the incident. Failure to do so significantly compromises the integrity of the deadly force investigation.

Deadly Force Review Issues

As noted above, the criminal investigation of this officer-involved shooting was presented to the prosecutor's office for review which found that the officers were justified in their use of deadly force. The seventeen page memorandum in support of this decision is limited to the following analysis:

The officers were justified in their use of deadly force. [The Subject] had fired six rounds from a shotgun into an occupied house in a residential neighborhood. The police were responding to this call when they located him in a residential neighborhood. The police were responding to this call when they located him by Shari's Restaurant, on a busy arterial in the middle of the afternoon. He refused repeated commands to drop his weapon and police had legitimate concerns for not only their safety but the safety of others.

As noted above, after the conclusion of the internal investigation, the Spokane Police Department convened an Administrative Review Panel who similarly determined in a one paragraph analysis that all involved officers' use of force was in compliance with the Department's Deadly Force Policy. The brief analyses provided by both the Prosecutor's letter and the Department's Administrative Review Panel failed to individually set out the justification and reason for use of deadly force for each involved officer and each use of deadly force.[2]

For example, the initial officer who first viewed the subject indicated that he was concerned as the subject got close to the restaurant that he would enter and create a hostage situation and that observation formed the basis for his first use of deadly force. It is not unreasonable to recognize this tangible real threat of harm to innocents in assessing the officer's decision.

Later in the scenario, one officer indicated that he fired because he saw that the subject was heading toward a residential area that had a school nearby as a basis for his use of deadly force. This officer has related a concern that is certainly more remote and less tangible than the restaurant articulation. In virtually all urban police responses to a subject there will be residences and schools nearby and thus the rationale articulated by the officer here could be used as a basis for using deadly force in virtually every one of them. Whenever such a blanket justification is expressed as the basis for using deadly force, it should invite discussion whether the threat meets the "imminent" circumstances in which deadly force may be used. In this case, however, the SPD's Administrative Review Panel did not provide any detailed analysis that examined the threat justification articulated by each officer but rather considered and justified the use of deadly force as if every officer was similarly situated. While not detailed in the analysis, apparently all rationales provided by the involved officers were accepted as justifying the use of deadly force without any distinction made about the reasonableness or the articulation for the officers' actions. While our assessment is not intended to substitute judgment about whether the use of deadly force by each involved officer was justified, an exacting force analysis would have more carefully examined each officer's use of deadly force, compared it to training, policy and Departmental expectations, and made individualized determinations as to each

[2] In some cases, the officers who filed multiple rounds articulated different reasons for the firing of those rounds.

individual officer's use of deadly force rather than a blanket finding for the use of force as a group.

Moreover, the scope of the internal investigation, Administrative Review Panel conclusion, and the DFRB review of the deadly force incident were all too narrow. Since the internal investigation was scoped as narrowly as it was, it failed to collect sufficient information for the eventual internal reviewers of the incident. The Administrative Review Panel focused exclusively on the officers' decision to use deadly force as a whole and did not individually assess and critique officer performance nor include any assessment of their tactics. As detailed below, the DFRB did consider some broader issues such as equipment but was reticent to constructively critique virtually any element of SPD's response and failed to evaluate the strength or weaknesses of the criminal and internal investigations.

Deadly Force Review Board

The SPD's DFRB consists of executives from the Department who are convened to review a deadly force incident, the response to the incident, and to examine issues of tactics, training, investigative activities, and equipment performance. Missing from the convened is the Ombudsman. SPD is to be commended for even convening such a Board since most similarly sized police departments in the country still only conduct a cursory paper review of such events. However, as noted in this report, a robust identification of potential issues and critique is lacking in the DFRB review of the shooting.

The DFRB did identify two scene preservation issues in their review. One issue that was identified was that after the incident a paramedic had apparently draped a blanket over the subject in an attempt to shield his body from public view and another walked through the crime scene disturbing expended shell casings on the ground. However, other than identify the issue, no concrete after-action plan was developed by the Board to address the issue identified either with its own or fire department personnel. More importantly, as noted above, the DFRB failed to address the actions of an officer who may have unnecessarily disturbed the crime scene by picking up the shotgun the subject was carrying from its initial resting place

Another issue identified by the DFRB was that while Officer H2's rifle was equipped with an EOTECH sight system, he missed striking the subject with all but one of the twelve shots he fired. The review determined that because the EOTECH is a battery sighting system, officers do not power the sight up until they anticipate deploying the weapon. The review determined that in this instance, Officer H2 claimed that he did not have time to turn the sight on before deploying the weapon.

The DFRB concluded that as a result, Officer H2 looked over the top of the sight which caused his rounds to go high. According to his interview, Officer H2 adjusted his aim and then looked through the window of the EOTECH to find that something was blocking his view. Eventually, Officer H2 was able to deploy the weapon in the manner in which it was designed.

According to the DFRB, the recommended additional training on use of the sights on the rifle had already occurred by the time the Board convened.

In addition, the suggestion was made to equip the response team with metal detectors to located shell casings and other metal objects, replacement weapons, and voice recorders. There was a suggestion about installation of in-car cameras but apparently no documented follow up came out of that discussion.

Finally, the DFRB recommended reality based training, quicker processing of the involved officers, refresher training on the legal requirements of when deadly force is allowed, consideration of the deployment of more two person cars, and to debrief the incident to the involved officers. However, there was no after-action plan developed or person assigned to coordinate all of the DFRB recommendations to ensure further consideration or implementation.

The identification of the matters raised by the DFRB were sound and certainly worthy of discussion and reform. However, other issues completely escaped the DFRB's discussion. Most prominently, as detailed below, the DFRB displayed an apparent hesitancy in constructively and exactingly critiquing the involved officers' tactical performance.

Conservation of Ammunition, Backdrop, and Use of Deadly Force

The number of shooters and the overall number of rounds fired in this incident is remarkable, particular since only two of the twenty-six rounds fired actually struck the subject. Despite this, the DFRB concluded that the officers were "disciplined" in their fire control.

Regarding backdrop issues, one stray bullet was discovered to have gone through a kitchen window and another bullet struck a non-involved vehicle. There were also a number of bullet strikes on the outside of the Spokane Tribal Building. Some of the bullets that were fired were never found. The investigation did not attempt to identify which shooting officers might have fired the stray bullets. Despite this paucity of information and analysis, the DFRB concluded that officers were aware of their surroundings and of their backdrop.

Whenever an officer-involved shooting involves a large number of shooters and a substantial number of rounds, it raises particular issues of concern. First, because officers are trained to stop a threat, each round that did not stop the threat suggests tactical or proficiency issues regarding that shooter officer since the delivery of the round did not meet its objective. Second, any use of rounds that is not on target raises the possibility that innocent bystanders or nearby residents will be struck by them. However, at the DFRB, the issues of target acquisition were only raised in evaluating equipment issues of the long gun and some non-specific discussion for additional tactical training.

Ideally, the review would have examined each officer's use of deadly force and an assessment of whether the officer was tactically sound and proficient when he fired. For

example, the DFRB would have discussed Officer H2's statement that after he fired a burst with the AR-15, the subject jumped up and down and whether that action provided a basis for continuing to use deadly force. At a minimum, firearms training experts should have been asked to assess how to better train each involved officer to ensure a higher level of performance in the future. These lessons learned could and should also have been exported to develop training regimens for the Department as a whole.

Cross Fire Issues

Responding Officer P stated that there was a cross fire issue that existed that prevented him from firing and he alerted other officers to the situation. Because of the number of responding officers, there may have been other officers with a potential cross fire situation but the interviews and subsequent investigation did not sufficiently plumb this issue to determine whether there were other cross-fire issues with other officers. While the DFRB praised Officer P for holding fire, our review found insufficient fact-finding for the Board to conclude that all of the officers were aware of cross fire situations and dealt with them optimally. Issues of preeminent officer safety such as cross fire concerns must be clearly identified during the investigative process and carefully considered during the subsequent review.

Other Tactical Issues

Officers H1 and H2 indicated to investigators that they broke cover in order to shoot at the subject. Best tactical practices and principles of officer safety discourage officers from engaging in such risky behavior.

Officer H2 said that the vehicle he was in stopped only ten feet from the armed subject. Another officer admitted that he had gotten too close to the subject causing him to need to use deadly force. Best tactical practices and principles of officer safety discourage officers from placing themselves so close to an armed subject.

Several of the officers described shooting at the subject while they were on the move, a disfavored technique that usually leads to missing the target.

During the review, none of these tactical choices were discussed, considered or critiqued by either the Administrative Review Panel or the DFRB.

Foot Pursuit

A number of officers went into foot pursuit of the subject, but it is unclear from the investigation whether each radioed that they were in pursuit. One officer noted that he lost sight of the subject during his pursuit and slowed down, a tactic consistent with principles of officer safety. Yet even this tactically desired decision was not addressed by the DFRB. Foot pursuits of an armed subject are inherently dangerous, yet there is no record that the DFRB discussed the

appropriateness of the tactic and whether there was sufficient communication and coordination of the foot pursuits.

Communication Issues

According to their interviews, Officers P and H1 never placed themselves on scene. While they offered explanations about their failure to do so, citing busy radio traffic, the investigation did not apparently examine the radio traffic to learn the degree of radio traffic and whether the account of the officers comported with other external evidence. If radio traffic prevents officers from effectively communicating with dispatch or each other, the review process should have examined this issue to determine whether effective strategies can be devised so that officers can communicate effectively with dispatch and each other regarding their location during future serious critical incidents.

Feedback from Initial Crime Scene

The investigation revealed that the subject had deployed his shotgun at the door of the residence when his father did not come out. However, it is clear that the rounds were not intended to strike an individual and no one was injured by the rounds. It is not apparent from the investigation whether those facts were known to responding officers at the initial scene when other officers were attempting to detain the subject. It is also not clear when officers arrived at the initial scene to determine whether any of the occupants were injured as a result of the subject's delivery of the shotgun rounds.

Had officers dealing with the subject known what was being learned about the incident at the initial scene, it could have reduced the threat the subject presented to some degree. However, because the investigation did not attempt to discern when that knowledge was learned, any subsequent review process would be unable to make any assessments on whether that information could have been communicated in a timely fashion to assist the officers in gauging the subject's threat level. This illustration proves how the review process will be cabined by what issues are identified and pursued during the investigation, and how the investigation needs to be wide-ranging in scope to cover any potential issues worthy of review.

Alternative Plausible Scenarios

Officers at the end of the incident asserted that the subject repeatedly refused to obey their commands to drop the weapon. That being said, Officer S stated that the subject was yelling at them in response but he could not hear what was said because of the patrol car siren. If the officers could not hear what the subject was yelling, it well could have been possible that the subject could not hear the commands the officers were yelling at him. During the review and analysis of this incident, this alternative plausible scenario was not considered.

Sometimes, noises such as police sirens negatively impact officers' ability to effectively communicate with each other and with subjects. Here, the fact that the officers were not able to hear what the subject was saying may have negatively impacted the ability of the officers to optimally respond. Lessons learned about turning off sirens when they are not needed and interfering with communication could have come out of this review. However, neither this potential scenario nor the potential lesson learned was explored during the DFRB review of the shooting incident.

The Subject Should Not Dictate the Police Response

There are references in the analysis of the incident that the subject created the situation that led to the use of deadly force against him. This conclusion is common among police officers but misses the point of progressive policing. A progressive policing model equips officers with strategies that do not allow subjects to dictate the response. It is the peace officer that must effectuate an effective plan of detention that avoids the use of deadly force if at all possible and still safely takes a dangerous individual into custody. The police should dictate the situation; not the subject, and should approach any tactical situation with that mindset. Any written conclusions about the subject's conduct should also not reinforce any notion that the subject is in charge or able to dictate the police response.

B. Date of incident: March 2010

In this officer-involved shooting, officers responded to a call (from subject's family member) that the subject was outside their home and armed with a firearm. The family had been involved in a dispute over their deceased father's collection of firearms. Officers A and B were the first to arrive at the location and observed the armed subject. Officer B thought he heard Officer A yell something at the subject. The subject then aimed his firearm (with laser light) at the officers and fired. Officer A returned fire. Officer B was "out of position" at the time and did not return fire. Officer A then obtained cover behind a jeep. The subject did not retreat or flee and was observed using the laser light on his firearm to gain target acquisition of the officers and other arriving units. At one point during the incident, both officers entered separate nearby homes in search of better positions. Officer A continued to engage the subject and fired the fatal rounds at the subject. Officer B never gained target acquisition of the subject and therefore did not fire his weapon. There was no formal administrative investigation conducted by SPD. The criminal investigation, which included the officers' voluntary statements, was reviewed by the Deadly Force Review Board and the Administrative Review Panel ("ARP") which addresses issues of policy compliance.

Investigative Issues

Formal Administrative Investigation: As mentioned above, in this case, SPD did not conduct a formal administrative investigation of this incident but simply repackaged the criminal investigation. The involved officers gave voluntary statements to the criminal investigators but

were not re-interviewed by SPD internal affairs investigators. The better practice is to re-interview the involved officers (and other relevant witnesses) in the administrative phase so that the Department can address individual officer actions and potential tactical issues not fully explored in the criminal investigation.

Organization: Similar to the criminal investigation of the November 2010 shooting incident (discussed above) there was no table of contents or exhibit list in this report. In addition, there was no summary of the incident in the investigative report making it difficult to sort out the sequence of events and also determine the involvement of a third officer (who was ordered on paid administrative leave).

First Names Used in Reports: Again, similar to the November 2010 report, there were instances in this investigation report when the subject and other witnesses were referred to by their first names.

Canine Unit: A canine ("explosive dog") was utilized to assist in searching for bullets and shell casings. There is no indication in the report, however, if the utilization of the canine resulted in additional found casings.

Diagrams: Unlike the November 2010 investigation, the report in this case did not contain a "to scale" diagram of the scene. Such diagrams are valuable tools to use during interviews in order to more accurately determine officer positions, target acquisitions, and movement.

Photographs: The investigative report contained a comprehensive photo log of the scene and surrounding area, officers, equipment and other physical evidence (i.e. shell casings).

Notable Post-critical Incident Practices

Notifications: After the officer shooting had been reported, SPD personnel made immediate and proper notifications to responding units including assisting law enforcement agencies in the county. Notifications were also promptly made to the Forensic Unit and Ombudsman. In addition, as a precautionary action, notification was made to a nearby school which was in session at the time.

Post-OIS Coordination: In the report, there was ample documentation of SPD personnel performing post-critical incident duties. For instance, on-scene briefings were conducted to investigators, responding units and assisting agencies upon their arrival. Also, a SPD sergeant directed units to set up a perimeter around the scene and crime scene tape was promptly erected.

Sequestering/Transport of Involved Officers: Per Department protocol, steps were taken to separate the involved officers. At the scene, the officers were placed in separate vehicles and then transported to the station.

Preservation of Physical Evidence: In the investigation report, it was documented that a fire truck may have moved casings from their original landing place. After identifying this issue, SPD personnel appropriately set up cones over the casings and documented the potential issue.

Waiver/Consent: Investigators obtained a waiver from the family who permitted the involved officer to enter their home. The legal search resulted in the discovery of shell casings inside the bedroom where one of the officers was positioned.

Assistance to Decedent's Family: Personnel contacted the decedent's sister and asked if she wanted a Chaplain to respond to her home to assist the family. The decedent's girlfriend was also contacted and presented with the same offer. Both accepted the offer and a Chaplain responded to their homes.

Deadly Force Review Board

As part of the SPD's post-incident review process, an Administrative Review Panel was convened and determined that the officer's use of deadly force was in compliance with the Department's policy. As stated above, the charge of the DFRB is to consider tactics, training and other relevant issues surrounding a use of deadly force. Similar to our comments made regarding the review of the November 2010 incident, the DFRB did identify some pertinent issues. For example, the DFRB assessed Officer A's decision to use a rifle (not his Department-issued handgun) which was equipped with an EOTECH sight.[3] The Board ultimately determined that, under the circumstances, the rifle was the best option since the subject had a laser sight device on his weapon (which the officers assumed was on a rifle) and provided the officer tactical advantages (enhanced target acquisition) over a handgun. Recognizing the benefit of using a rifle with the EOTECH sight, the DFRB recommended that an audit be conducted to establish how many of the Department's rifles should be equipped with the EOTECH sight and also recommended that it be determined how much it would cost to outfit the rifles with that device.

The DFRB also discussed the advisability of the officers to "slow down" the response. The Board specifically noted that since the subject was located slowing down the response may have been appropriate and may have provided officers and responding units time to plan and execute a more methodical approach to apprehending the subject. As with the November 2010 shooting, the DFRB's review, however, was narrow in scope and failed to specifically address the following tactical and decision-making issues:

- The officers' initial approach and advancement on the subject: When the two officers responded to the scene they were aware that the subject was armed but the record indicates that neither officer had appropriate cover when they contacted the subject.

[3] An EOTECH sight is an electronic sight that does not broadcast a laser beam but rather transposes a crosshair over the subject within the sight.

When the subject fired his weapon, Officer B was "out of position" and therefore did not return fire. Officer A ran for cover behind a jeep after the initial volley of rounds were deployed.

- Partner-splitting: At one point, each of the officers had entered separate homes to gain a better visual of the subject. While doing that, the officers lost sight of each other.
- Lack of communication: There is no indication in the record that while the officers were separated that they continued to communicate to one another about their movement or the location of the subject. In fact, Officer A had a visual of the subject but it appears he did not communicate that information to his partner. After the initial volley of rounds, Officer B moved into different positions but never obtained a visual of the subject and therefore did not fire his weapon. Also, there is also no indication that the officers were broadcasting their movements to other units over the radio.
- The Decision to Enter Occupied Dwellings: Both officers entered occupied homes (invitations by the homeowners) to obtain a better visual of the subject. Officer A monitored the subject from a second story bedroom. Clearly, entering the homes was not part of the initial plan to apprehend the subject. The DFRB did not address the potential legal, liability, or safety issues related to that decision.
- Backdrop Issues: The subject was hiding behind a corner of a home. The incident occurred just after 0600 during a work day—a time when many residents are up and getting ready or leaving for work or taking to their children to school/daycare. The DFRB did not address this issue.

C. Recommendations

- We recommend that the Internal Affairs investigations of deadly force incidents be available to the public.
- We recommend that the investigative reports that are publicly available be well-organized with the summary report at the beginning of the document.
- We recommend that protocols be developed with participating investigative agencies so that subjects, involved officers, and civilian witnesses are not referenced in the reports by their first names.
- We recommend that involved officers continue to be transported away from the scene individually.
- We recommend that officers be relocated to a station setting which is comfortable and ensures preclusion of any potential for discussion about the shooting incident.
- We recommend that the investigative and review process focus and identify any scene contamination issues.
- We recommend that SPD continue to produce scaled diagrams of the scene and that investigators use the diagrams during the witness interviews.

- We recommend that SPD continue to use waivers and document consent during the investigative process.
- We recommend that the use of leading questions by any member of the interviewing team be eliminated and that the review process include review of the interview transcripts to ensure that inappropriate leading questions have not been deployed by interviewers.
- We recommend that involved officers be interviewed in detail on the date of the incident about their observations and actions. Should an officer decline to provide a voluntary statement, the officer should immediately be subjected to a compelled interview.
- We recommend that the SPD Administrative Review Panel individually consider every articulated justification of force by each involved officer to determine whether each use of deadly force meets departmental expectations.
- We recommend that the internal investigation and subsequent review of deadly force incidents exactingly plumb and consider tactical issues such as cross-fire, backdrop, and number of rounds fired in determining whether they comply with best principles and office safety.
- We recommend that tactical lead ups to the use of deadly force such as vehicle pursuits, vehicle approaches, and foot pursuits be included in the scope of the investigation and subsequent review.
- We recommend that communication issues be carefully explored and considered during the investigative and subsequent review process.
- We recommend that the review process consider alternative plausible scenarios in identifying potential lessons learned.
- We recommend that the SPD communicate to its officers the importance of not allowing subjects to dictate their response.
- We recommend that a formal administrative investigation be conducted in all deadly force incidents and that they include interviews of the involved officers and other relevant witnesses.
- We recommend that the SPD continue to make prompt notifications to appropriate stakeholders.
- We recommend that Response Team members continue to promptly take command of a scene, conduct timely briefings and erect crime scene tape around the perimeter of the scene to secure the area.
- We recommend that the SPD continue to use canines to search for evidence at scenes of officer involved shootings. We also recommend that the outcome of the canine search for evidence be documented in the investigative report.
- We recommend that the SPD continue to take photographs of all relevant evidence and include a comprehensive photo log in the investigative file.
- We recommend that SPD continue to make contact with a decedent's family/significant others and offer them the opportunity to be counseled by a Chaplin.

III. Use of Force Cases

A. Force Reporting/Review: Process and Practices

All SPD officers are required to provide a "full description" of his/her use of force in an incident report.[4] We found that, in general, the officers did provide sufficient detail in incident reports about their own actions and involvement in a force incident. These statements are critical to a supervisor's formal review of an incident and help create a complete record. Equally important is documentation of what an officer observes during a use of force incident. SPD officers, however, are not required by policy to report their observations of other officers' actions. The absence of this mandate was evident in the police reports. As we observed in one case, for instance, in an encounter with a domestic violence subject, one officer applied a lateral neck restraint (Level 1) technique on the subject and the officer and subject went to the ground. The officer then applied a Level 2 lateral neck restraint and the subject may have momentarily lost consciousness. Two backup officers arrived and one applied two strikes to the subject's torso and assisted in handcuffing the subject. Here, the initial responding officer did not report the strikes the backup officer deployed on the subject and the backup officer did not report the neck restraint hold deployed by the initial officer. In addition, a witness officer did not write a report of any of his observations. In another case, a guild attorney reminded one of the officers that they are instructed to write only what they did and not report about what other officers did.

A more robust reporting policy which includes observations made by both involved and witness officers is a better practice and provides a more complete record of how the incident unfolded. Also, per Department policy, there is an expectation that officers be cognizant of fellow officers' use of force[5] so those observations should be documented. In essence, SPD officers are hired and trained to be effective witnesses and it is incumbent upon those witnesses to not only report what force they used but also to report what force they saw.

Once a use of force is reported a determination is made whether the conduct rises above the "formal review" threshold and requires a supervisor to complete a use of Force Administrative Report.[6] If a formal assessment is triggered then the incident receives a closer scrutiny of review and requires a supervisor to collect relevant evidence and statements from the involved officers, witnesses and the subject of the use of force.[7] Although supervisors were committed in obtaining statements from the involved officers, in several cases, there was no record of statements from others. For instance, in the example provided above, the subject was not interviewed about the force used on him. In another use of force case, which involved a man and woman assaulting another man, there was no documentation that the supervisor attempted to obtain a statement from the subject or the female who was involved in the assault.

---

[4] See SPD policy 300.4: *Reporting the Use of Force*
[5] See SPD policy 300.1.2: *Duty to Intercede*
[6] See SPD policy 300.4.1: *Notifications to Supervisors*
[7] See SPD policy 300.5: *Supervisor Responsibility*

As part of the formal review process, a supervisor is also required to make a recommendation/finding about the use of force. The supervisor's completed report and recommendation is reviewed by the chain of command—as a second layer of review—and they are also provided an opportunity to document comments about the force incident. We found that in several cases the comment section was left blank by reviewers. A closer review of the force package revealed that this issue was a Department policy shortcoming as opposed to a supervisor performance lapse since the force review form itself notes that such comments are "optional". In our view, supervisors tasked with assessing use of force incidents should be required to document his/her observations about the force used and also consider the review form as an opportunity to examine any related training, tactics, policies and supervision issues.

B. Expand Scope of Review

In our review, we noted that not all potentially relevant aspects of a use of force were addressed. These aspects include actions taken by officers before and after a use of force incident. While these aspects may be secondary to the force, they nonetheless warranted the Department's attention.

In one case, for example, officers went to a subject's residence to arrest him for vehicle theft. While the subject was standing at the threshold of the front door, the officer asked him to step outside. The subject refused. The officer then told the subject that he was going to arrest him and directed him, again, to exit the residence. The subject refused and began to make movements that suggested he was contemplating "fight or flight." The subject then moved one foot over the door threshold at which time the officer reached out and grabbed the subject. The subject pulled away and began to recede back into the residence. The officer pursued the subject inside the residence, pushed him, and then performed a takedown. The subject sustained a minor injury when he stuck his forehead on a picture frame during the use of force. The use of force was adequately addressed in the review but actions taken by officers prior to the use of force were not reviewed or documented and deserved some attention. Below, is a list of potential issues that warranted assessment during the review process:

- Was the entry into the residence legal?
- Did the officers' plan to contact the subject at his home contemplate that there may have been others inside? In the incident report, it stated that there was an adult female and "small boy" inside the home.
- Did the decision to approach the subject at his residence provide the officers optimal tactical advantage? To avoid a potential barricaded subject incident, would a planned traffic stop have been a viable tactical option?
- Did the officers have intelligence that the subject may have had weapons inside the residence? The report states that inside the home (where the use of force incident took place) there were Samurai swords hanging on the wall.

- Were the assisting officers adequately positioned when initial contact was made with the subject? In the report, one officer states that after he heard the detective talking to the subject he believed that there was a brief struggle at the front door but admitted, "[I] couldn't see very well based on my position in the front yard." Does this information suggest overall less than optimal tactical planning and positioning? Does it suggest that there was a lapse in communication?
- Was there a contingency plan if the subject refused to voluntarily exit his residence to be arrested?
- Was there adequate communication among the officers during the incident? [In fact, there may have been communication among the officers, but none of that is documented in the report.]

In another case, a subject was transported from the hospital to the jail by the officer who used force on him. We found this practice to be repeated in another case. The better practice is for an uninvolved officer to be instructed to transport the subjects when feasible. Reasons for a diversion from the practice may be explainable (subject is non-resistant, there is a limited number of units in the field, etc.) but if they exist, those reasons should be documented in the report and should be addressed during the review process. In another case, although the use of force was evaluated, the reviewers did not address the fact that the involved officer did not report the force to a supervisor until the subject was being transported to the jail. This same officer (who was involved in the use of force) also questioned the subject about his involvement in the alleged assault of another man. Reviewers did not offer observations about this officer's post-use-of force conduct.

In another case, we noted that the police report referred to the subject by his first name in the narrative, a practice which seems unnecessary and informal and deserved to be documented with a notation to follow up with the officer.

Review and assessment of these additional issues can provide a glimpse into possible individual officer performance or training issues, risk management matters and Department policy gaps. Failure to expand the scope of review and evaluate these secondary issues is a missed opportunity for the Department and prevents it from taking immediate corrective action and implementing meaningful and timely reform.

C. Thoroughness of Evidence Gathering

In our review of cases, we noted instances where some force packages included critically relevant materials. For instance, in one case photographs were taken of the subject and officer's injuries. In addition, in another case, officers did a good job documenting their attempt to take a photograph of the damage caused inside a residence (broken picture frame) as a result of a use of

force and included, in the report, the female resident's refusal to oblige. In another case, officers appropriately checked for video surveillance that may have captured the force incident.

Other force packages, however, were of inconsistent quality regarding inclusion of secondary materials. For instance, we found that the reports typically did not indicate the status of any charges, in particular, those related to the officers' use of force (i.e. resisting arrest, assault on a police officer) sought against the subjects. The outcome of these charges is of value in any force incident review. For example, while there may be many reasons for the prosecutor's decision not to file charges against the subject, that decision is worthy of further inquiry to learn whether the decision was impacted by any concerns by the prosecutor's office about the actions of the involved officer.

D. Canine Cases

SPD currently maintains a K9 unit; five handlers, five patrol dogs and one supervisor (full time supervisor) and a lieutenant (part-time unit commander). The canines are an invaluable tool for the officers when searching for and apprehending subjects. And because the dogs are trained to "bite and hold" (not bark and hold), successful deployments and apprehensions typically result in injuries to a subject. Like other uses of force, the use of Department canines is subject to policies, procedures, and review. As part of our audit, we analyzed three individual canine incidents and assessed the uses of the canines in each case and evaluated the way in which SPD reviewed the incidents.

1. Consideration of Other Tactical Options

Overall, canine handlers performed well describing the circumstances that led to the deployment of a canine. Although the Canine Reports contained good articulation of the reasons and necessity for the use of the dog—which comported with Department policy—the force review did not address whether other tactical approaches may have been available or optimal before releasing a dog. In one case, for example, the facts suggested that officer safety issues may have warranted the consideration of an initial alternative approach before deployment of the canine.

In this case, officers responded to a disturbance/burglary in progress call. The victim reported that the subject (his stepson) was kicking in doors and windows of the residence. When officers arrived, the subject barricaded himself in a room attached to a garage. Based on the record, the room was small and appeared to be empty. In addition, the door of the room was notably "thin and flimsy" and had a "large gap" under it. Officers were also informed by the victim that the subject was "always armed with knives." There was no information, however, that anyone saw the subject with a weapon. It was also unknown if there were other weapons in the room.

When K9 personnel arrived a briefing was conducted and it was determined that there was sufficient information to deploy the canine. Verbal announcements were made and when the subject refused to come out, the door was breached and the canine was released into the small dark room. The canine alerted and eventually made contact with the subject who was promptly apprehended. The subject was unarmed. In the review, the actions of the K9 officer and the effectiveness of the canine deployment were deemed "Excellent!" There was no discussion in the review form, however, whether a different initial approach may have been more tactically sound. For instance, one option may have been to call the specialized unit (SWAT) to assist in the apprehension of the barricaded subject. Also, with appropriate planning, the use of a diversionary device (i.e. flash/bang or gas) could have been a potential option and been deployed under the large gap under the door providing personnel with valuable seconds of advantage. A diversionary device used to disorient the subject may have forced him out of the dark room and out into the open area where officers, behind appropriate cover, would have been at a tactical advantage to observe whether the subject had a weapon. We do not conclude that these other approaches were superior to the one adopted by the involved officers in this case; our point is simply to suggest that during any robust review, alternative approaches and strategies should be part of the after-action discussion.

In another case, a K9 officer responded to a call that a robbery subject had fled into a residential neighborhood. The canine alerted to a man under a trailer and then dragged out the subject by his hand. The subject then tried to punch the canine, at which point, the K9 officer kicked the subject in the shoulder twice. The decision to deploy the canine instead of going into a foot pursuit was tactically wise, particularly after SPD lost sight of the subject. What was not addressed in the review, however, was why the K9 handler did not have other officers (members of SPD SWAT who were with the K9 handler when he used force on the subject) go tactical since the handler was involved with dealing with the canine.

2. Additional Documentation

Canine Reports also contained good articulation and detail of the subject's injuries (i.e. description of injury (rakes, punctures, etc.), (location of injury on body, severity, etc.). The reports also contained photographs of the subject's injuries. One detail missing from the reports, however, was information regarding the length of time of the canine bite. This information may help identify unusual patterns and/or explain an injury. For example, a longer bite may explain the severity of a subject's injury (longer bite may have been necessary because subject continued to be resistive/assaultive). In addition, if, on average, a canine hold is no more than 40 seconds but one canine consistently engages a subject for two minutes, if documented, the Department will be in a better position to identify a potential issue (i.e. the canine fails to immediately release when ordered or handler fails to timely order release). Documenting and collecting this data makes it easier for the Department supervisors to evaluate whether the deployment of the dog was reasonable and not excessive. In addition to the time a canine engages with a subject, the

following is a list of some other questions that should be considered when assessing the reasonableness of a canine deployment and use of force.

- Was immediate apprehension of the subject critical?
- Was the subject posing a danger to himself or others?
- Was the subject armed?
- Was the subject actively fleeing or resisting arrest or was the subject simply hiding?
- Were there other tactical options to apprehend the subject?
- Did the dog bite the subject once or multiple times?
- Was the subject given an opportunity to surrender (i.e. hear verbal warning)?

3. Announcements/Warnings

Summaries of the incidents were clear and concise and were fair representations of the evidence. They also succinctly documented steps taken before deployment of the canine. For instance, before deploying a canine, the K9 handler documented that announcements were made notifying the subject that he was under arrest and ordering him to surrender. Although verbal announcements are intended to afford a subject an opportunity to surrender, they should also be used to protect the community and notify persons within the containment area of the potential use of the canine. One way to do that effectively (so that the announcements are heard over a large geographical area) is to pre-record the announcements and play them loudly from a radio car public address system. The start and end times of the pre-recorded announcements should be documented in the reports (i.e. announcements began at 2220 and ended at 2230).

The utilization of the public address systems will increase the likelihood that the announcements are heard by the subject and others within the containment area. Also, in the reports, although containment personnel performed well in documenting that they heard the K9 announcements, there was no indication that the area was canvassed to learn if citizens in the area heard the announcements, as well. Obtaining statements from uninvolved third parties is valuable information, particularly in instances where a subject claims he/she did not hear the announcements.

4. Dispositions

The Canine Report contains a section entitled, "Canine Effectiveness" in which the reviewer can comment on the efficacy of the operation and use of the K9. It is also a section in which a reviewer can address training concerns. In one K9 case, the reviewer stated that the canine effectiveness was "Perfect." Although, in this case, the use of the canine was effective and provided a safer and swifter manner to locate the subject and allowed arresting officers to

take the subject into custody with minimal level of danger, the reviewer should simply state whether the use of the canine was effective and why and state whether the actions taken by the K9 handler were within Department policy and met Department expectations.

In the same Canine Report, the review stated in the "Patrol Support" section that the officers' actions were "Perfect." Again, the reviewer should simply state whether the officers' actions were effective and fell within Department policy. Dispositions should be free of editorial comments.

In one case, the section requiring "K9 Supervisor Comments" was blank. There was a notation that there are no supervisor comments because it was the sergeant's first deployment with his canine. It is unclear why this reason would justify failing to complete the report. All sections of the report should be completed.

5. Assess all Uses of Force

In one case, a canine alerted to a man (robbery subject) hiding under a trailer. The canine dragged out the subject by his hand. The subject tried to punch the dog at which time the K9 officer kicked the subject in the shoulder twice. The K9 officer ordered the dog to release and the subject was taken into custody. The canine contact was reviewed for appropriateness but the kicks by the K9 officer were not. All uses of force related to a canine deployment should be addressed in the reports.

E. Recommendations

- We recommend that SPD expand its force reporting policy to require that officers report all force they observe. Supervisors should enforce and monitor compliance with the policy.
- We recommend that, in formal use of force reviews, supervisors make a concerted effort to obtain statements from all relevant witnesses to a use of force, including statements from witness officers, subjects and uninvolved third parties.
- We recommend that the force review form be revised to require all reviewers to document his/her comments about the use of force and use the form to address any training, tactics and policy issues.
- We recommend that, in police reports, subjects and witnesses are referred to by their full or last names.
- We recommend that the Department broaden its scope of force reviews and pursue all potentially relevant aspects of an incident, including ancillary issues to a use of force.
- We recommend that the Department include all relevant information in its force packages/reports, including the status of any charges against the subject. Supervisors should evaluate this information as part of the use of force review.

- We recommend that, in canine cases, supervisors address whether other tactical approaches may have been available or optimal before deploying a canine.
- We recommend that, in canine cases, incident reports record the length of time of the canine bite so that the Department will be in a better position to identify any potential issue with the canine or handler and also so that supervisors can better evaluate whether the deployment of a dog was reasonable and not excessive.
- We recommend that, in canine cases, the Department consider making pre-recorded canine announcements and play them from a radio car public address system to ensure that the advisement is heard by the subject and others within the containment area. We also recommend that announcement start and end times be documented in the reports. We also recommend that the Department attempt to obtain statements from uninvolved parties to learn whether they heard the announcements.
- We recommend that, in canine cases, supervisors complete the comment section of the reports. Also, we recommend that notations/dispositions be free of editorial comments.
- We recommend that, in canine cases, all uses of force related to a canine deployment be assessed and addressed in the reports.

IV. Internal Affairs Investigations

Timeliness of internal affairs investigations is a critical aspect of the administrative process. Prompt conclusion of an investigation allows for swift and constructive Department intervention in cases where officer misconduct has been identified. In this respect, we found that the internal affairs investigations were completed in an extremely timely manner (approximately two months). We also found that the investigative files contained a good tracking record of the administrative process including when the investigation was completed and sent to the command staff for review. There was also a well-developed record of when the Department contacted the Ombudsman to ask for input. We also found commendable the Department's detailed (addressed specific allegations) and timely letters to complainants regarding the outcome of the investigations.

A. Notable Investigative Practices

The following are examples of other notable investigative efforts and practices:

- Files contained transcripts of officers' interviews.
- In one investigation, it was noted that the complainant did not have visible injuries or red marks on his body. The investigator did a good job including photographs of no apparent injuries for the record.
- During the review, a lieutenant noted that two officers were not interviewed except at the scene and appropriately sent the case back for additional investigation.

- In one case, when contacted, a subject said he wanted to talk with an attorney before being interviewed and never re-contacted the investigator. SPD appropriately did not close out the case but continued to pursue the allegations.
- In another case, there was a rigorous attempt to look for evidence. The area was canvassed and there was a notation that there were no surveillance cameras that captured the use of force incident.

B. Missed Investigative Opportunities

We did, however, find instances where investigative practices were less effective. The following are some examples of missed investigative opportunities:

Failure to interview potential witnesses: In our review, we found a chronic failure to obtain statements from all potential witnesses. In one case, one of the witness officers stated that there was a female standing in "close proximity" to where the force incident unfolded. Another officer at the scene mentioned that a female citizen may have been a witness to the incident. The reports also indicated that there may also been a second female who may have witnessed the physical interaction between the involved officer and the subject. These potential witnesses were not interviewed and the investigative file did not indicate whether efforts were made to contact them.

In another case, the subject's wife was a witness to at least part of the encounter yet was not interviewed. A subject, in another case, provided an eyewitness to the incident. He was not interviewed but his voice mail message about the incident was used to justify the force. In allegations of officer misconduct, the investigations should be thorough and contain statements from all relevant witnesses. Voice mail messages should never suffice as a substitute for a full investigative interview.

Evidence gaps in case file: As with use of force reports, in the internal investigations we reviewed, the status of any charges sought against subjects was not included in the investigative reports. Also, in one case, it was noted that the complainant was evaluated by jail medical staff and that there was no request for him to be transported to the hospital. However, there is no information regarding the actual medical assessment of the individual. If the medical staff records indicated that the complainant had no visible injuries then that should be noted in the investigative record. In another case, the investigator did well to note that there were no visible marks on the involved officer's hand. A photograph, however, of the officer's hand would have completed the record.

Leading questions: In several cases, at the end of the interview, the officers were asked the following leading and not helpful question: "Were tactics and techniques that you used consistent with your training?" Also, during an administrative interview, a subject officer was asked, "Do you feel like the amount of force you used during this incident was excessive in any

way?" This question which is designed to elicit a "no" response does nothing to advance the concepts of an objective review.

Questionable Interview Protocol: In one case, although the investigation addressed the involved officer's actions leading up to the physical intervention, the subject officer interview did not address all the specific allegations made by the complainant. To the credit of the review panel, this investigative shortcoming was recognized and a request was made to address the issue. Instead of re-interviewing the subject officer, however, the officer was asked to respond—via email—to the follow up questions (he admitted placing his knee in middle of the subject's back but denied performing elbow and knee strikes as alleged by the complainant.) For follow up interviews, the subject officers should be provided with all proper admonitions. Subject interviews, including supplemental interviews should be conduct in-person and should be recorded.

Failure to document attempt to contact complainant: In one case, it is noted in the file that the complainant failed to appear for a scheduled IA interview and did not return "calls" to the investigator. Ideally, the file should contain better documentation of the attempts made to contact the complainant (i.e. dates of telephone messages). Also, the file should contain copies of certified letters which sought to schedule the investigative interviews. Detailed notes documenting the multiple attempts to contact the complainant will show the Department's diligence and pursuit of fairness in the process.

Findings not supported by evidence: In one case, the reviewing lieutenant found the use of force in policy because of the subject's "assaultive" behavior. However, in the interviews, neither officer described the subject's behavior as assaultive. It is unclear how the lieutenant concluded that the subject was assaultive since neither officer described the actions of the subject as such during their interviews.

Failure to name involved officer as subject: In one case, the sergeant was not named as a subject of the investigation, even though he used force. Apparently, he was not named a subject because the complainant did not complain of the sergeant's actions. Best practices do not limit the identification of subject officers to those raised by the complainant and, in this case, since he too used force, the sergeant should also have been named as a subject in the investigation.

Narrow Scope of Review: In one case, officers responded to a subject's residence after he threatened to blow up the power company. When the subject was on the porch, officers told the subject he was under arrest and asked him to turn around and put his hands behind his back. The subject did not comply with the orders, at which time, an officer then went hands on with the subject and gained control of him using a straight arm bar and application of a lateral neck

restraint. A sergeant gained control of the subject's arm and placed it in a wrist lock.[8] The officer then released the neck restraint hold and the subject was handcuffed. The articulated reason for the use of force was that the porch had an abundance of items on it that could have been used as a weapon or could have injured the subject. However, there was no discussion about the tactical advisability of asking the subject to step off the porch before dialoguing with him. In another case that involved officers locating a domestic violence subject in the field, the officers called for backup. The officers, however, engaged the subject before backup arrived. Though, in the report, it appears that the officers articulated potential reasons for not waiting for backup, this issue was not addressed in the investigation.

C. Recommendations

- We recommend that SPD interview all potential witnesses regarding officer misconduct investigations.
- We recommend that investigative reports contain information regarding the status of any charges sought against the subjects.
- We recommend that investigative reports contain any relevant medical assessment/documentation and that they indicate whether a complainant had any injuries. Photographs of the injuries of subjects and officers should be included as part of the investigative record.
- We recommend that investigators refrain from asking leading questions.
- We recommend that investigators address all aspects of alleged misconduct during an administrative interview. We also recommend that subject officers compelled to a supplemental interview be provided with all proper admonitions and that they are conducted in-person and are recorded. We also recommend that witness officers be admonished but not be provided subject rights.
- We recommend that the investigative file contain documentation of attempts made to contact complainants (i.e. dates of telephone messages, copies of certified letters which sought to schedule the investigative interviews, etc.)
- We recommend that supervisors ensure that their findings are supported by the evidence.
- We recommend that the City identify resources to ensure that those with supervisory responsibilities be able to perform those roles instead of being required to perform line functions.
- We recommend that, in internal investigations involving the use of force, all involved officers who use force are named as subjects.

---

[8] It appears that recent resource scarcity has required sergeants in the field to perform street officer roles.

- We recommend that SPD broaden the scope of internal investigations to include secondary issues that may raise individual officer performance or training issues, risk management matters and Department policy gaps. Once those issues are flagged the Department should take immediate action and implement meaningful reform.

V. Other Recommendations

A. Expand Criteria for Use of Force Administrative Reports

Per SPD policy, supervisors are only required to complete a Use of Force Administrative Report if (1) use of force resulted in an injury (no report if minor handcuff marks or minor face injury as a result of prone handcuffing) (2) subject complains of injury (even if no visible injury observed) (3) Application of Carotid Neck restraint (Level 2—subject rendered unconscious) (4) all Taser applications and (5) firearm discharges.

The criteria for prompting a Use of Force Administrative Report should be expanded to include head strikes; knee strikes; elbow strikes; open and closed hand strikes; baton/flashlight strikes; all applications of less lethal devices (OC spray, foam or wood rounds, beanbag rounds, etc); carotid neck restraint (Level 1)--technique attempted but not successful--subject was not rendered unconscious); all takedowns and prone handcuffing incidents that result in any head or facial injury. Expanding the review of these uses of force will help the Department evaluate its practices/policies and individual officer actions. A collection of this data, for example, can help managers track and monitor what types of force is being used Department-wide and can also help identify the frequency certain techniques are used by certain officers.

B. Consider Revising Threat Level for Authorization of Lateral Neck Restraints

In the force reports, we noted a frequent use of the lateral vascular neck restraint to subdue subjects. There are two levels of this control technique.[9] A lateral vascular neck restraint level 1 (subject not rendered unconscious) may only be used by an officer to obtain control of a physically non-compliant subject. The level 2 lateral vascular neck restraint (rendered unconscious) may only be used when an officer believes/perceives that a non-compliant subject may assault an individual or an officer. We found that this differential threat level in the policy gave rise to questionable justification for the technique.

In one case, for example, a subject refused commands to stop then squared up with the officer in what the officer perceived as a fighting stance. The subject refused additional commands at which point the officer applied a level 1 lateral vascular neck restraint. The officer and the subject then went to the ground. The subject continued to try to break free and grabbed

[9] See SPD policy 300.2.5: *Lateral Neck Restraint.*

the officer's fingers. In the report, the officer stated that he considered this action "assaultive" and warned the subject that he would render him unconscious if he did not let go of his fingers. The officer then performed a level 2 vascular neck restraint and the subject may have momentarily lost consciousness. In our view, it is uncertain whether the subject's behavior could be considered assaultive. A natural reaction to having a level 1 restraint applied is for a subject to try to interrupt the hold. The natural actions of the subject then seemed to be used to justify a greater level of force. In other words, a subject who may resist application of the hold may be simply fighting for air rather than trying to assault the officer.

For that reason, we recommend that the Department consider authorizing a level 1 or level 2 lateral neck restraint only when the subject is displaying assaultive behavior.

C. Consider Further Development and Use of an Early Intervention Tracking System

The best way for the Department to accurately track and monitor use of force cases, including critical incidents, and investigations is to have an integrated database. To ensure that the Department maximizes the value of the information, data would have to be promptly inputted for all documented incidents. Citizen complaints and law suits could also be maintained in an integrated database. The database can provide Department executives/managers with information that can assist them in measuring and managing use of force incidents, provide them updated information regarding the status or outcome of a force review or an investigation and give insight regarding Department-wide complaint history and systemic trends, etc. If information is accurately and promptly recorded, the data system can be also be used as an early warning system to identify employees with potential performance issues. Having the ability to easily query a database to learn about Department-wide issues or individual officers allows timely and proactive intervention ensuring professionalism and accountability. While we have been informed that SPD may have begun collecting such data, we saw no evidence of the data being used in the investigations we reviewed. In other words, we saw no officer performance history included with the investigative reports and no mention of any officer performance history in assessing the performance of the officer in the incident being reviewed.

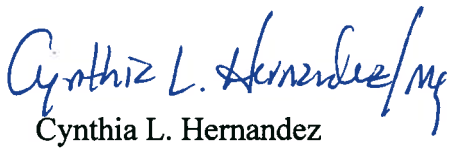
VI. Conclusion

We have appreciated the opportunity to review SPD's investigative and review process and issues related to use of force. In sum, while there is much to be respected about the quality of the work done by the Department, as with any law enforcement agency, there is always room for improvement. We hope that the recommendations offered here are accepted in that vein.

If you have any questions or comments regarding the content of this Report, please do not hesitate to contact us.

Very Truly Yours,

Michael J. Gennaco
Attorney
OIR Group



Cynthia L. Hernandez
Attorney
OIR Group