The Portland Police Bureau: Officer-Involved Shootings and In-Custody Deaths

First Follow-Up Report

Police Assessment Resource Center
August 2005

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About PARC

The **Police Assessment Resource Center (PARC),** a non-profit organization, is dedicated to strengthening effective, respectful, and publicly accountable policing. PARC serves as an "honest broker," working in cooperation with law enforcement executives, civic and government officials, civilian oversight professionals, and other interested constituencies to improve police performance. Based in Los Angeles and New York, PARC provides direct services to jurisdictions throughout the United States and serves as a national resource center specializing in the formulation and dissemination of model policies and procedures to manage and reduce the risk of police misconduct.

Through its direct services, PARC assists officials in individual jurisdictions as they develop and strengthen oversight systems. PARC conducts reviews of police policies and practices; evaluates external and internal oversight mechanisms; collects and analyzes relevant data; performs accountability audits; and helps police leaders develop and implement management strategies that promote accountability.

As a national resource center, PARC performs research on issues of concern among law enforcement professionals and community members, and provides guidance regarding policing practices and oversight of the police. PARC publishes a monthly newsletter, *Police Practices Review*; maintains an informational website; sponsors forums on issues and trends in the field of policing; conducts and publishes independent research on emerging issues and enduring challenges in policing; and catalogues model policies and procedures.

A copy of this report is available on-line at www.parc.info.

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MEMORANDUM

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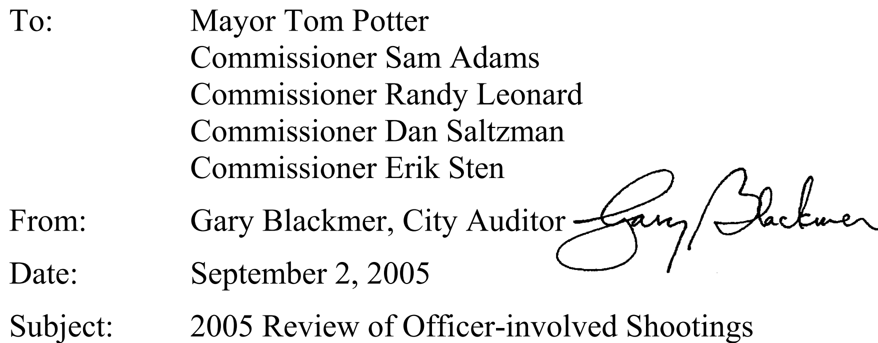

From: Gary Blackmer, City Auditor

Date: September 2, 2005

Subject: 2005 Review of Officer-involved Shootings

This is the second report prepared for my office, as called for in the City Code. City Council instructed that these reviews emphasize policy-level recommendations with the goal of identifying any strategies for reducing the possibility of future incidents. We hired the Police Assessment Resource Center (PARC) to conduct the first review, which was issued in 2003.

The City Code calls for regular reviews and 14 more closed shooting incidents were evaluated, along with the Police Bureau's progress in implementing the policy recommendations of the previous report. I am very pleased to see many substantial changes undertaken by the Bureau on those recommendations.

You will also find responses from the Police Chief and Mayor, addressing the issues raised in the report as well as the ten additional recommendations, attached at the back of the report.

I need to remind our community that these regular reviews set a standard of accountability that, to my knowledge, no other city has been willing to undergo. Many members of the Police Bureau have cooperated and contributed immensely to making this a constructive effort, and we appreciate their participation.

I urge the City Council and our community to recognize and support the Police Bureau's progress. Only with a continuous, constructive dialogue among all the interests can there be lasting change in the way the Police Bureau meets the needs of our community.

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Executive Summary

In the first follow-up report to its August 2003 Report ("PARC Report") on Portland Police Bureau ("PPB") officer-involved shootings and in-custody deaths, the Police Assessment Resource Center ("PARC") examines how the PPB has responded to certain recommendations in the PARC Report and also reviews 14 officer-involved shootings that occurred from July 1, 2000 through December 31, 2001.

In an effort to ensure that the PPB's policies and practices relating to officer-involved shootings and in-custody deaths were up-to-date and consistent with good practice, the Independent Police Review Division ("IPR") of the Office of the Portland City Auditor retained PARC in 2002 to examine those policies and practices. The PARC Report made 89 recommendations for changes in the PPB's deadly force policies, investigation and review procedures and practices, tactics, and information management.

IPR has retained PARC to issue five additional follow-up reports to the PARC Report. This First Follow-Up Report finds that the Police Bureau, led by Chief Derrick Foxworth, has responded very positively to most of the 28 recommendations examined this year. Those 28 recommendations were selected by PARC and IPR for examination this year because they involved changes to written policies and procedures that are basic to the good practices we recommended and would have been expected to have been implemented in the two years since the PARC Report.

The PPB appropriately revised its deadly force policy to emphasize the sanctity of human life, became a national leader by requiring its members to avoid actions that unnecessarily precipitate the use of deadly force, significantly improved its policy for using deadly force against fleeing felons, and adopted progressive policies relating to shooting at or from moving vehicles. One important recommendation not adopted by the PPB is to revise its policy to authorize the use of deadly force only when no other alternatives are reasonably available.

The PPB adopted in whole or in significant part most of the PARC Report's recommendations relating to the procedures for investigating officer-involved shootings and in-custody deaths. The PPB declined, however, to adopt one of two investigative models of deadly force incidents recommended by PARC that are consistent with good practice, and instead modified its Homicide-only investigative model. This change, nonetheless, will enhance the quality of its administrative investigations by increasing the roles of the Internal Affairs and Training Divisions, and the PPB has indicated that in a year's time it will consider whether to adopt one of the investigative models recommended by PARC.

No action has been taken on the important recommendation in the PARC Report—directed to the Portland City Council—to create permanent civilian oversight of PPB administrative investigations and tactical analyses relating to deadly force incidents. PARC's findings from reviewing five years of shooting investigations demonstrate the need for such ongoing contemporaneous civilian oversight. PARC recommends that the new Mayor and Council create the necessary oversight of this critical police function.

As anticipated, in light of the fact that the PARC Report was not issued until 2003, our examination of the 14 officer-involved shooting incidents from mid-2000 through 2001 raised many of the same issues we found in the cases (from 1997 to 2000) reviewed for the PARC Report.

Based on the cases reviewed this year, we do address and make recommendations concerning two subjects not directly addressed in the PARC Report: extracting noncompliant persons from vehicles and obtaining medical aid without undue delay for persons wounded in deadly force incidents. PARC makes a total of ten new recommendations in this Report. Most build on recommendations made in the PARC Report. In addition to the new recommendations on vehicle extractions and rendering medical aid, PARC recommends that the PPB adopt a policy that prohibits officers from responding to routine patient management situations in mental health facilities and requires advising all mental health providers in the City of that policy.

In future reports we will review the progress on the 61 recommendations in the PARC Report not followed up on in this Report. In two years we will begin the review of officer-involved shooting incidents that postdate the release of the PARC Report. PARC values the opportunity to establish a long-term working relationship with the Portland community and the PPB to improve its policies, procedures, and practices relating to these critical issues that literally affect life and death.

1. Introduction

In August 2003, the Police Assessment Resource Center ("PARC") issued a report entitled "The Portland Police Bureau: Officer-Involved Shootings and In-Custody Deaths," which is generally referred to as the "PARC Report." The report was commissioned by the Independent Police Review Division of the City Auditor's office, and involved a review of 32 officer-involved shootings and two in-custody deaths that occurred in Portland from 1997 through mid-2000. Based upon that case review and other relevant information, PARC made 89 recommendations to the Portland Police Bureau ("PPB") relating to policy issues and the quality of officer-involved shooting investigations. The PARC Report may be found on-line at http://www.portlandonline.com/auditor/index.cfm?c=27070 and at http://www.parc.info/pubs/pdf/ppbreport.pdf. As described below in greater detail, this is the first of five annual reports assessing the PBB's progress in implementing the recommendations of the PARC Report.

We stated in the PARC Report that we believed that, if followed in good faith, our recommendations would produce benefits for the City and the Police Bureau, as well as for Portland's police officers and the people they serve. While the PPB's response to the PARC Report is still ongoing, and as we discuss in Chapters 2 and 3, can still be improved in various respects, the response to date has been very positive. Chief Derrick Foxworth and his command staff have embraced many of the PARC recommendations and have made serious, good-faith efforts to implement those recommendations. The Bureau has broadened its horizons over the past two years, repeatedly seeking knowledge from other police departments around the country and from respected national police organizations.

In April 2004, with the approval of the City Council, the Independent Police Review Division ("IPR") of the City Auditor's office retained PARC to issue five reports over a five-year period measuring progress on the recommendations of the PARC Report

and reviewing additional officer-involved shooting cases (and in-custody death cases) as they become "closed." Pursuant to the ordinance that authorized IPR to hire an expert to review officer-involved shooting cases, the review was restricted to "closed" cases, which are defined as cases as to which all criminal and civil proceedings, if any, have been concluded and the two-year statute of limitations for filing civil suits has expired. The ordinance also restricted the issues to be identified during the review to "any policy-related or quality of investigation issues that could be improved." "Policy-related issue" is defined by the ordinance as: "a topic pertaining to the Police Bureau's hiring and training practices, the Manual of Policies and Procedures, equipment, and general supervision and management practices, but not pertaining specifically to the propriety or impropriety of a particular officer's conduct." Portland City Code § 3.21.020 (S).

Because there will be a series of follow-up reports and because none of the cases from 2000 and 2001 being reviewed this year had the benefit of the recommendations made by the PARC Report, IPR and PARC decided that this year's report would examine the progress on 28 recommendations that can be measured principally by changes in written PPB policies and procedures. IPR and PARC also decided to focus in this report on recommendations that required changes in written policies and procedures because practices cannot be expected to change until the necessary amendments to policy and procedure have been implemented. It was thus important to measure progress on the recommendations that would provide the framework for changes in practices both on the street and in deadly force investigations and reviews.

Chapter 2 of this report looks at the PPB's progress on recommendations concerning deadly force policies (PARC Report Chapter 3) and policies regarding foot pursuits and officers shooting at and from moving vehicles (Recommendations 7.11 and 7.15). Chapter 3 of this report examines the PPB's response to recommendations concerning investigation procedures (PARC Report Chapter 4) and the City's response to the recommendation for civilian oversight of PPB administrative investigations of officer-involved shootings and in-custody deaths (Recommendation 5.15).

We have also reviewed for this report 14 closed officer-involved shooting cases that occurred between July 1, 2000 and December 31, 2001. There were no in-custody death cases during that 18-month period. We emphasize here, and we will reiterate below, that the shootings and the investigations in the 14 cases we reviewed this year all occurred well *before* the PARC Report was issued. Thus, there is no expectation on our part, and should be no expectation on any reader's part, that what occurred in these cases could have been influenced by the PARC Report's recommendations. While the proposition that the PPB should not be judged for noncompliance with recommendations that were issued well *after* the events being reviewed is an obvious one, we think it important to try to ensure that no reader labors under a mistaken conception of the relevant sequence of events.

Because the shootings and investigations being reviewed occurred before the PARC Report was issued, to the extent that the same issues as were identified in the PARC Report occur in this year's set of cases, we will note but not belabor those issues. While it is important to document whether similar issues occur during the 2000-01 period as occurred during the 1997-2000 period, neither the community nor the PPB will benefit from a lengthy repetition of all the same points, same analyses, and same recommendations as were presented in the PARC Report. To the limited extent that we have discovered new issues, they will receive a more comprehensive presentation in Chapter 4, where we deal with risk management and tactical issues, and in Chapter 5, where we deal with investigation and review issues. When we make recommendations beyond those made in the PARC Report, they are set forth in bold in the text and are numbered sequentially starting at "2005.1" to differentiate them from the 89 recommendations originally made.

Future reports will review officer-involved shootings that occurred after the August 2003 release date of the PARC Report. With respect to those post-August 2003 incidents, we will analyze whether the PPB's tactics, investigation, and review conform to the recommendations of the PARC Report.

This year's report builds on and often refers to the PARC Report. Although this report can be read without reference to the PARC Report, we think that it would be a mistake to do so. There are a multitude of references to material and analyses in the 222 pages of the PARC Report and its large Appendix that are only summarized or briefly referred to in this much shorter report. We encourage the reader to have available a copy of both the PARC Report and its Appendix while reading this report. Page references to the PARC Report will be preceded by "PR" and references to the PARC Report's Appendix will be preceded by "PR Appendix."

PARC reviewed the following materials on the 14 cases that were included in this year's cohort of cases:

- Such official PPB files of the investigations of each of these incidents as were available, including interviews with officers and civilians, tapes, transcripts of 911 calls and MDT transmissions, videotapes, photographs, medical records, and autopsies;

- The available personal files of the investigating detectives;

- Such after action reports and executive review determinations as were generated;

- City of Portland risk management files for those cases on which a claim was filed;

- Non-privileged portions of City Attorney's files for those cases on which a lawsuit was filed; and

- The files relating to the nomination for and awarding of commendations.

As was the case in 2003, the completeness of the files was a substantial problem. Records that certainly or probably once existed could not be located and were thus not available for our review. While no file was so incomplete that the PARC reviewers could

not reach overall conclusions about each case, our reviewers were sometimes thwarted in reaching conclusions on discrete issues. We are hopeful that the PPB's record retention and maintenance practices today have improved dramatically from what they were in and before 2001. We do know that since 2003 the PPB has relatively contemporaneously sent copies of the case-specific records needed for the annual officer-involved shooting reviews to IPR for safekeeping until the time comes to review those cases. That procedure should markedly improve the completeness of the files in the future.

In addition to reviewing the case files, we met—sometimes on more than one occasion—with numerous PPB officials and others who provided us with information, history, and context.

At the PBB, we met with the Chief; the Assistant Chiefs; the heads of the Detective, Internal Affairs, Management Services, Personnel, and Training divisions; the two supervisory sergeants from the Homicide detail; and other supervisors and staff, sworn and civilian. We met with the President of and attorney for the Portland Police Association, the union that represents PPB sergeants and officers; and the President of the Portland Police Command Officers Association, the union that represents lieutenants, captains, and commanders. Additionally, we met with the Chief Deputy District Attorney in the Multnomah County District Attorney's Office.

We also met with members of the Citizen Review Committee, the Community Police Organizational Review Team (CPORT), and the Albina Ministerial Alliance Ad Hoc Committee for Police and Civil Redress, as well as representatives of community groups, activist organizations, and attorneys concerned with issues related to policing.

We gave those we met our contact information and encouraged them to call or e-mail us during the course of this project with additional information and insights that would further our work.

We reviewed all policies and procedures issued by the PPB since the PARC Report and a number of new and revised training manuals and lesson plans.

In addition to PARC staff, four consultants—all with a wealth of sworn law enforcement experience and broad knowledge of policing practices across the country—participated in the file reviews and in the formulation of the conclusions reached by this report. Brief biographies of PARC's four consultants follow.

Ruben B. Ortega was Chief of the Salt Lake City Police Department from 1992-2000 and Chief of the Phoenix Police Department from 1980-1991. Joining the Phoenix department in 1960, he rose through the ranks before becoming Chief. In both Salt Lake City and Phoenix, he instituted community policing and created police-citizen review boards that oversaw uses of force and discipline. Chief Ortega was President of the Major Cities Chiefs Association and for ten years served on the Executive Committee of the International Association of Chiefs of Police ("IACP"), where he was instrumental in the formulation of IACP's first Model Policy on Deadly Force. He was appointed to numerous commissions by Presidents Reagan, George H.W. Bush, and Clinton, and by the Governors of Arizona and Utah. He graduated from the FBI Academy's National Executive Institute and the Community Oriented Policing Program at Harvard University's John F. Kennedy School of Government.

Bernard K. Melekian has been Chief of Police in Pasadena, California since 1996. Prior to that, he spent 23 years as an officer and supervisor in the Santa Monica Police Department. His most important goal when he became Chief in Pasadena was to try to end killings of young people. He has lowered the youth homicide rate by 85 percent, for which he recently was honored nationally. Chief Melekian instituted community service policing following existing neighborhood lines and established programs to improve interactions between law enforcement and persons with mental illness. He has been Secretary and a Director of the Police Executive Research Forum ("PERF") for the past four years and was chairperson of the California Attorney General's Blue Ribbon

Commission on SWAT Policy. He graduated from the FBI National Academy and the California P.O.S.T. Law Enforcement Command College.

Ronald L. Davis is Chief of Police in East Palo Alto, California. He previously served 19 years with the Oakland Police Department, including Inspector General of the Department. He is a former member of the federal monitoring teams in Washington, DC and Detroit, and the former Region Vice President of the National Organization of Black Law Enforcement Executives ("NOBLE"). Chief Davis serves as a police expert for the United States Department of Justice and is a member of the IACP Professional Standards Committee. A nationally recognized expert in racial profiling and police accountability, he developed the first bias-based policing training course in the country, which he has presented in 15 states to over 4,000 law enforcement executives and government officials. He is a graduate of the Senior Executive Program at Harvard University.

Christopher M. Moore has been a sworn police officer in California for 22 years, most recently as a Lieutenant with the San Jose Police Department. From 2000-2002, he served as Commander of the Internal Affairs Unit of the San Jose PD where he was responsible for managing the disciplinary process for more than 1,800 employees and supervising the department's administrative investigations of officer-involved shootings. From 1999-2000, as a White House Fellow, Lt. Moore served as counsel to U.S. Attorney General Janet Reno. Among his Justice Department responsibilities were managing the Attorney General's conference on police uses of force nationally and reviewing use of force policy. Lt. Moore is a graduate of the California P.O.S.T. Law Enforcement Command College, and currently serves as an instructor in the P.O.S.T. Internal Affairs and Police Management courses at San Jose State University. He is a member of the State Bar of California.

Significant time was devoted to reviewing the 14 investigative files and other materials related to those cases. All the first reviews done by staff members were performed by staff with sworn police experience. Two team members, always including one of the highly experienced law enforcement professionals profiles above, were

assigned to each file with each reviewer expected to provide an independent assessment of the issues in the case. In one case presenting particularly difficult issues, a third team member examined the file. The review team met for a full day in February 2005 to discuss themes drawn from the individual cases and the PPB policies and procedures drafted in response to our recommendations.

Drafts of our final report were provided to the Mayor, the PPB, the City Auditor, IPR, and the City Attorney. Drafts were also provided to, and comments sought from, members of the review team. After circulating drafts of our report, we met with PPB command staff, a representative of the Mayor, a deputy city attorney, the City Auditor, and the director of IPR to discuss our findings and recommendations, and to respond to concerns about our report. We carefully considered the constructive suggestions made to us concerning our report by those who read the draft. Neither the PPB nor anyone else who read the draft in any way tried to impinge on our independent judgment as to our findings and recommendations.

The Mayor and PPB were provided an opportunity to respond in writing to our report. The Mayor's and PPB's responses were drafted after PARC's report was completed. The process set up by the City Auditor's office did not provide an opportunity for PARC to respond to the specific language in the Mayor's and PPB's responses. Our extensive discussions with the PPB, however, led us to believe that we had sufficient information concerning the limited areas in which we and they disagree to have adequately anticipated the Bureau's response.

Having detailed what we did do, we should point out what PARC did not do. We did not review any cases other than the 14 that occurred within the prescribed time period. And consistent with the terms of the city ordinance that restricted our analysis to "policy-related issues," we did not re-investigate the 14 cases whose investigations we reviewed; nor do we provide any assessment whether the officers involved in these cases acted lawfully or within PPB policy.

2. Responses to PARC's Recommendations On Deadly Force Policies

Chapter 2 addresses the Portland Police Bureau's responses to date to the PARC Report's recommendations on deadly force policy, shooting at moving vehicles, and foot pursuits. Throughout this and the following chapter we will set forth the PARC Report's original recommendation before discussing the PPB's response to that recommendation.

In some instances, the Bureau has considered a recommendation PARC made and has chosen a change in policy or procedure different than PARC recommended. If that different response is consistent with good practices and fulfills the intent of the recommendation, we will say so. Sometimes there is more than one good practice with respect to a particular issue. On the other hand, where good practices in the field suggest that the changes implemented by the Bureau should have gone further or in a different direction, we will discuss how the provisions in question can be improved.

I. Deadly Force Policy

Effective August 1, 2005, after nearly two years of revisions, the PPB issued a substantially revamped version of Policy Manual Section 1010.10, which sets forth the Bureau's policy on the use of deadly force. "Section 1010.10," as we will refer to the August 1, 2005 directive, is set forth at page 11 of the annexed Appendix.

A. Recommendation 3.1: *The PPB should add a preamble or mission statement to its written deadly force policy, underscoring the Bureau's reverence for the value of human life and its view that deadly force is to be used only where no other alternatives are reasonably available.*

Section 1010.10 has added the following new language to the PPB deadly force policy (Appendix Page 11):

> The Portland Police Bureau recognizes and respects the integrity and value of human life, and that the decision to use deadly physical force is the most important decision that a member will make in the course of his/her career. The use of deadly force will emotionally, physically and psychologically impact the member involved, the subject the deadly physical force was directed at, and the family and friends of both and can impact the community as well.

Section 1010.10's preamble relating to the "Sanctity of Life" is an important and valuable addition to the Bureau's deadly force policy. Its placement at the beginning of the policy provides significant emphasis to the points being made. The preamble, however, can be improved in one important respect.

The preamble would better reflect the Bureau's values and would be more useful to PPB members, particularly in training, if it explicitly stated that deadly force should be used only when no alternatives are reasonably available. The Alaska Department of Public Safety policy says this well:

> The Department, recognizing the integrity of human life, authorizes officers to use deadly force against another person only when … the officer has no other reasonable and practical alternative ….

Operating Procedures Manual Section 107.020(D) (August 1, 2002), a copy of which is set forth at Appendix page 49.

The Los Angeles Police Department policy provides another effective formulation:

> Deadly force shall only be exercised when all reasonable alternatives have been exhausted or appear impracticable.

Los Angeles Police Department Manual of Policy and Procedure, Volume 1, Section 556.40 (2005), a copy of which is set forth at Appendix page 64.

The New York Police Department policy provides another formulation that makes clear the restraint that officers should employ before using deadly force:

> The New York City Police Department recognizes the value of all human life and is committed to respecting the dignity of every individual. The primary duty of all members of the service is to preserve human life.
>
> The most serious act in which a police officer can engage is the use of deadly force. … Respect for human life requires that, in all cases, firearms be used *as a last resort*, and then only to protect life. [Emphasis added.]

NYPD Patrol Guide, Section 203-12 (January 1, 2000), a copy of which is set forth at Appendix page 65.

The PPB's reluctance to state in its preamble that "deadly force is to be used only where no other alternatives are reasonably available" is puzzling because it has adopted just that formulation in the portion of Section 1010.10 dealing with "Shooting At a Moving Vehicle," where it prohibits such shooting unless (Appendix, page 12): "There are no other means available at the time to avert or eliminate the threat." The PPB likewise uses nearly identical language in the portion of Section 1010.10, dealing with "Shooting From a Moving Vehicle" (Appendix, page 13). If the PPB deems this standard both desirable and workable for situations involving shooting at or from a moving vehicle (we are in full agreement), we fail to understand why the PPB has concluded that the standard would be inappropriate and dangerous when applied to deadly force situations generally.

The argument advanced by the PPB that such a standard is inappropriate because it would make police officers conduct too complicated a thought process before using deadly force is unpersuasive. If police officers in such disparate jurisdictions as Alaska, Los Angeles, and New York are capable of determining not to use deadly force until they

reach the conclusion that no other alternatives are reasonably available, we are confident that the officers of the PPB are fully capable of applying the same standard. Unless and until PPB officers have made a mental determination that no other alternatives are reasonably available, they should not use deadly force.

The more specific the Bureau's statement of values on the sanctity of human life, the more specific the training provided members of the Bureau will be. With academy and in-service training that reinforces this value and applies it in simulations, the Bureau can demonstrate its true belief in the sanctity of human life. To guide that essential training, the Bureau's deadly force policy should be unambiguous that deadly force will not be used if there are other reasonable alternatives.

B. Recommendation 3.4: *The PPB should consider whether it would be appropriate to revise its written deadly force policy to expressly require officers to refrain from taking actions that unnecessarily lead to the use of deadly force*.

In response to PARC's recommendation, the PPB added the following sentence to Section 1010.10 (Appendix, page 12):

> Members of the Portland Police Bureau should ensure their actions do not precipitate the use of deadly force by placing themselves or others in jeopardy by engaging in actions that are inconsistent with training the member has received with regard to acceptable training principles and tactics.

This important statement makes the Portland Police Bureau a national leader on this issue. We are particularly impressed that the statement specifically refers to training and tactics. In incorporating this sentence into its deadly force policy, the Bureau is demonstrating an understanding of one of the central themes of the PARC Report. While most officer-involved shootings meet the legal standard for the use of deadly force when the trigger is actually pulled, many of those uses of deadly force were potentially

avoidable had greater restraint, better tactics, more thoughtful planning, or more proactive supervision been employed.

Having adopted this forward-looking policy provision, the task for the PPB is to ensure that the principles underlying this policy statement are consistently taught in training and are fully employed in the investigation and review of deadly force incidents. For instance, this principle should inform and guide the analyses pursued during the administrative investigations the Bureau will conduct on deadly force incidents.

C. Recommendation 3.3: *The PPB should revise its deadly force policy to prohibit officers from using deadly force to stop a fleeing felony suspect unless they have probable cause to believe that the suspect (1) has committed an offense involving the actual or threatened infliction or threat of serious physical injury or death, and (2) is likely to endanger human life or cause serious injury to another unless apprehended without delay. In addition, the policy should make clear that even in those circumstances, deadly force should not be used where (1) other means of apprehension are reasonably available to the officers, or (2) it would endanger the lives of innocent bystanders.*

The PPB has significantly improved its deadly force policy in Section 1010.10 by adding the words "and immediate" to Paragraph b. of the section entitled "Deadly Physical Force," as follows (Appendix, page 12):

> A member may use deadly force to effect the capture or prevent the escape of a suspect where the member has probable cause to believe that the suspect poses a significant and immediate threat of death or serious physical injury to the member or others.

By doing so, the Bureau has made clear that there must be reasonable grounds for believing that death or serious injury will occur if there is any delay in apprehending the suspect. The policy could be further improved by stating that deadly force should not be used where other means of apprehension are reasonably available to the officers, and by

specifying that deadly force should not be used, even in such circumstances, if it would endanger the lives of innocent bystanders.

D. Recommendation 7.15: *The PPB should revise its existing policy on the use of firearms against moving vehicles. The revised policy should include a preface explaining that shooting at moving vehicles is dangerous and generally ineffective, and should embody the following guidelines:*

- *Officers shall not fire at moving vehicles except to counter an imminent danger of death or serious bodily harm to the officer or another person.*
- *Officers shall only fire at a moving vehicle when no other means of avoiding or eliminating the danger it presents are available at that time.*
- *Officers shall not place themselves, or remain, in the path of a moving vehicle.*
- *Officers shall take account of risks to vehicular and pedestrian traffic, and to any other bystanders, before deciding whether to fire at a moving vehicle.*
- *Officers shall take account of risks to vehicle occupants, who may not be involved (or may be involved to a lesser extent) in the actions necessitating the use of deadly force before deciding whether to fire at a moving vehicle.*

Section 1010.10 effectively addresses this recommendation in two new sections entitled "Shooting At a Moving Vehicle" and "Additional Considerations" (Appendix, page 12). In addition, Section 1010.10 adds another excellent section entitled "Shooting From a Motor Vehicle" (Appendix, page 13). The new provisions unambiguously point out the dangerousness and ineffectiveness of shooting at or from a moving vehicle. They clearly prohibit officers from engaging in the "poor tactics" of placing themselves, or remaining, in the path of a moving vehicle and then using the threat from the moving vehicle to justify using deadly force. By adopting these provisions, the PPB has joined the departments across the country that are taking the lead to better safeguard officers and the public in these situations through evasive action rather than ineffective and dangerous discharges of weapons.

E. Recommendation 3.5: *The PPB should revise its deadly force policy to clearly articulate when officers may draw or point their firearms and when they should re-holster them. In addition, the PPB should require officers to report in writing each instance in which they draw and point a firearm at another*.

The PPB has followed this recommendation to the extent that, since August 1, 2004, officers are required to report when they point their firearms at another. In all other respects, the Bureau has not acted to date on this recommendation.

Of particular concern is the fact that the PPB has not added provisions to its deadly force policy as to *when* officers may draw or point their firearms and *when* they should re-holster them. Policy guidance on this frequently used precursor to the use of deadly force is essential. Officers need concrete guidelines as to when they may appropriately draw or point their weapons and when they should re-holster them. The Bureau needs those guidelines so that, if weapons are inappropriately drawn or pointed or not re-holstered, it can hold officers accountable for deviations from those guidelines. The LAPD has had such a policy for the past 28 years, and police departments in Washington, D.C. and Cincinnati have adopted such guidance in the last several years. See PR 39-41.

As of August 1, 2004, officers are required by PPB Manual Section 1010.20 (Appendix, pages 22-23) to report on a Use of Force Report that they pointed a firearm at a person and the distance the person was from them. Copies of the Use of Force Report, a July 19, 2004 Tips and Techniques training bulletin concerning the report, and a September 8, 2004 memorandum from the Chief on the same subject are set forth in the Appendix at pages 24, 26, and 30, respectively. While we know from the Community Police Organizational Review Team (CPORT) Summary Report (January 2004), pages 4-5, and from press reports (*The Oregonian*, news articles, April 20, 2004, and July 23, 2004; editorial, April 24, 2004), that the Portland Police Association and many members of the Bureau vigorously opposed this reporting requirement as being inconsistent with officer safety, the command staff tasked with considering this recommendation found that

many nearby law enforcement agencies—including the Oregon State Police, Multnomah County Sheriff's Office, and police departments in Beaverton, Hillsboro, and Tigard—had had such requirements for years without jeopardizing officer safety.

Requiring a Use of Force Report when officers point their weapons is an important positive step which could be significantly improved by broadening the requirement to include drawing weapons. The Metropolitan Police Department in Washington, D.C. has required such reporting since 2002 without any reported diminution of officer safety. Metropolitan Police Department General Order 901.07, at 9 (2002) (copied at PR Appendix page 129).

Of significant concern is that when more than one officer points a weapon, only one officer is required to complete a Use of Force Report. July 19, 2004, Tips and Techniques training bulletin, at Appendix pages 26 and 29; September 8, 2004 memorandum from the Chief, at Appendix page 30. Neither document states how officers are to determine which officer is required to file the Use of Force Report. Nor does either document suggest how the reporting officer—who presumably would have been in a dangerous situation if a firearm was pointed at a person—is expected to observe which other officers pointed their weapons or otherwise gather that information before writing a Use of Force Report. With respect to the Bureau's contention that situations where more than one officer draws a weapon "are rare," we suggest that if officers are only pointing their weapons when there is reason to believe that deadly force may be necessary, it would be surprising that the second or third officer on the scene would not perceive a similar danger and take a similar action.

The "multiple officer" exception to the requirement of reporting the pointing of weapons is inconsistent with principles of accountability and, without clear rules on who has the responsibility to report and how that person is expected to ascertain what other officers did, is unworkable. Every officer who uses any other type of force is personally required to report that use of force. Tips and Techniques training bulletin at Appendix page 26. There is no principled reason for lessening the reporting requirements when a

firearm is pointed. Every officer who points or draws a weapon should be required to report that use of force.

F. Recommendation 3.2: *The PPB should expand its written deadly force policy to provide that certain uses of force, such as strikes to the head or other vital areas with impact weapons, may not be used unless the officer is justified in using deadly force.*

To date, the PPB has not made the recommended addition to its policy on deadly force.

The use of deadly force is not limited to firearms. The PPB has a responsibility to provide adequate guidance to its members concerning all types of uses of deadly force. While Section 1010.10 (see Appendix page 12) appropriately identifies weapons and techniques that can constitute deadly force, the policy does not provide more specific guidance on when strikes with impact weapons amount to deadly force. Consistent with the agencies whose policies are discussed at PR 28-30, the PPB's policy should make clear that strikes with impact weapons to the head and other vital parts of the body constitute deadly force.

II. Other Substantive Policies

A. Recommendation 3.6: *The PPB should require its officers to record their use of force on a separate Use of Force Report. The PPB should use the information from these reports to analyze and manage its officers' use of force. The PPB should also log and track information from such reports in its early warning system.*

As discussed above, the PPB introduced Use of Force Reports in August 2004 consistent with the PARC recommendation. The Bureau's planned early intervention system, which will allow it to analyze and manage officers' uses of force is not expected

to be operational for up to two more years. Because no department in 2005 can claim to be appropriately managing risk without an operational early warning system, we urge the Bureau to ensure that development of the system does not lag.

Recommendation 2005.1: The PPB should set a firm deadline for making its early intervention system operational and should prioritize its resources so as to ensure meeting that deadline.

B. Recommendation 7.11: *In order to effectively prevent the unnecessary exposure of its officers to the risks associated with foot pursuits, the PPB should adopt and enforce a policy mandating the use of sound foot pursuit tactics by its officers.*

The PPB is in the process of formulating a foot pursuit policy. An April 28, 2005 draft of such a policy is set forth at Appendix page 8. While the Bureau's decision to formulate a foot pursuit policy is an excellent one, the draft policy leaves room for substantial improvement, including the following:

- Creating a greater emphasis on the dangers of foot pursuits, consistent with the PPB's training documents that label foot pursuits as "one of the most dangerous police actions" officers can expect to perform in the course of routine patrol work. Supervisor In-Service Training, 1997-98.
- Making officer and public safety the prime consideration in determining whether to initiate or continue a foot pursuit.
- Providing more affirmative direction to officers, rather than leaving most pursuit decisions to officers' discretion, subject only to various considerations.
- Presumptively banning solo pursuits.
- Requiring two or more officers engaged in a pursuit to terminate that pursuit if they do not remain in sight of and in communication with all other pursuing officers.

- Terminating a pursuit if a suspect's identity is known, making apprehension at a later time probable, so long as the suspect does not pose an immediate threat.

In drafting its policy, the Bureau will benefit by relying in particular on the IACP Model Policy on Foot Pursuits (February 2003) and the accompanying IACP publication, "Foot Pursuits: Concepts and Issues Paper" (February 2003).

3. Responses to PARC's Recommendations On Deadly Force Investigation Procedures

We turn now to the Police Bureau's responses to the PARC Report's recommendations on procedures for investigating officer-involved shootings and in-custody death cases. We also consider the City's response to the recommendation for civilian oversight of investigations of administrative issues and analyses of tactical decisions arising out of officer-involved shootings and in-custody deaths.

I. Investigative Framework

A. Recommendation 4.1: *The PPB should replace its current Homicide-only model of investigating officer-involved shootings and in-custody death cases with a broader, multidisciplinary approach, such as the Internal Affairs Overlay Model or the Specialist Team Model used by most major law enforcement agencies — with the Los Angeles Sheriff's Department and Washington, D.C. systems serving as examples of best practice.*

Over the past two decades most police departments the size of the Portland Police Bureau, or larger, have stopped using the Homicide-only model of investigating officer-involved shootings. The reason for this shift has been that while Homicide detectives are well-equipped to conduct a criminal investigation—determining whether the involved parties (police and civilian) should be charged with a crime—they lack the training and the perspective necessary to investigate officer-involved shootings from the two other perspectives from which those shootings should be analyzed. The latter two perspectives are administrative—whether the involved officers violated the department's rules and regulations and therefore should be subject to discipline; and tactical—whether the involved officers followed their training and performed in a tactically sound way and whether the underlying policy or tactical training needs to be changed.

Jurisdictions which have moved away from the Homicide-only model have instead adopted one of two different models. The first, which we term the Internal Affairs Overlay model, leaves Homicide responsible for controlling the crime scene, conducting the criminal investigation, and taking voluntary statements from the involved officers. ("An involved member is a member who is involved in the actual application of deadly physical force or directs another to use deadly physical force." Section 1010.10 [Appendix, page 14].) At the same time, however, Internal Affairs ("IA") investigators—sometimes joined by staff from Risk Management and/or Training—conduct the administrative investigation, responding to the crime scene and participating in Homicide's interviews of civilian and officer witnesses. They do not, however, participate in (but may monitor from another room) Homicide's interview of the involved officers in order to avoid any appearance of coercion that might render the officers' statements inadmissible in a criminal proceeding. The IA investigators receive all of Homicide's investigatory materials, including tapes and transcripts of interviews of involved officers.

If the District Attorney or grand jury rejects prosecution, Internal Affairs interviews the involved officers, using compulsion if necessary. Under this model, Internal Affairs is involved from the inception, significantly speeding up the conclusion of the IA investigation. Upon the conclusion of its investigation IA prepares a summary report that, along with the case file, is presented as part of the agency's review process.

Other police agencies have removed Homicide from officer-involved shooting and in-custody death cases altogether. They have embraced what we call the Specialist Team model, in which a stand-alone group of specialists investigates all aspects of officer-involved shootings and in-custody deaths. Unlike Homicide and regular Internal Affairs investigators, these special investigators typically do not have caseloads other than officer-involved shootings and in-custody deaths, and sometimes other high-risk uses of force. Specialist Teams often provide team members with advanced tactical and investigative skills training to permit them to determine whether officers could have safely approached the situation in a manner less likely to lead to the use of deadly force.

The PPB has traditionally employed the Homicide-only model, but has recently grafted onto that model IA involvement after Homicide has finished its work. After the grand jury presentation has concluded, all investigative reports have been filed, multiple photocopies of the file have been made, and the file has been organized and indexed—a process that takes approximately two months from the date of the incident—the Homicide detail of the Detective Division turns its officer-involved shooting file over to the Internal Affairs Division. IA then analyzes the case, with the assistance of the Training Division, from the administrative and tactical perspectives. Instead of an Internal Affairs Overlay model, the PPB has adopted a Homicide-and-then-Internal-Affairs model.

Section 335.00 of the Policy Manual (effective July 5, 2005) provides that IA, in coordination with Training, "will review the officer-involved shooting, and conduct an administrative investigation *as needed,* to determine if the member's actions were within Bureau policy and procedures" (Appendix, page 4; emphasis added). Section 335.00 also contradicts itself as to whether administrative investigations of in-custody deaths and uses of force that result in hospitalization are mandatory or discretionary with the Chief. Paragraph a.1. (Appendix, page 4) explicitly makes investigations of such cases discretionary with the Chief. Paragraph a.2. (Appendix, page 5) requires IA investigations of all cases that "fit the criteria" for the Use of Force Review Board—a category that includes all in-custody deaths and uses of force that result in hospitalization. Investigations are required to be completed within ten weeks, which seems at least double the period that should be necessary in the vast majority of cases since virtually the entire investigation will have been done by Homicide, and Homicide generally has its investigation completed and ready for a grand jury presentation within two weeks.

Section 335.00 provides that Training will provide the Use of Force Review Board with a written analysis of all officer-involved shooting and in-custody death incidents (but not uses of force that result in hospitalization). The Training Division's analysis is to focus on "[t]actics, policies, equipment … level of force used … [and] [t]raining provided to the member" (Appendix, page 5).

Although the involvement of IA and Training is positive, that involvement is too little and too late to reap many of the benefits of the two models now adopted by most departments the size of the PPB. IA is not involved in and cannot influence the Homicide investigation as it unfolds. All the investigative advantages of seeing the shooting scene, monitoring the interviews of all witnesses, and being able to influence the investigation as it proceeds are lost when IA does not become involved until after Homicide has completed its investigation. Furthermore, while Internal Affairs can completely re-investigate a case ("as needed"), including re-interviewing every witness, that duplication is not going to occur too often. More typically, IA will seek clarifications here and there, possibly conduct an interview or two, but will largely accept the investigation performed by Homicide. That means the information gathered for the investigation will largely be from the criminal perspective because that perspective is what the detectives doing the investigation are charged to operate within.

The PPB's Homicide-"plus" model suffers from the same weaknesses of perspective as the pure Homicide-only model. Moreover, in a rare case where a great deal of re-investigation in fact occurs, the investigation will still suffer from being delayed, with all the liabilities that delay breeds. We are encouraged, however, that the Bureau has informed us that it intends to evaluate its experience with its hybrid model after a year and is considering the possibility in the future of including IA and Training in the units that respond to the scene of an officer-involved shooting.

In addition to the qualitative problems caused by the delay in IA's investigation, the PPB model creates a series of other problems because of the delayed involvement of Internal Affairs. Shielding involved officers and witnesses from outside influences until IA interviews them, or decides not to, becomes harder and harder as time elapses. Communication restrictions, as has already happened once in 2004, may have to be extended to the point that involved officers are prohibited from obtaining the benefits of a Critical Incident Stress Debriefing ("CISD"), which generally occurs immediately after the grand jury presentation. Delaying IA's involvement undercuts the safeguards geared to protect the integrity of the information being gathered and creates avoidable problems,

as we discuss in connection with our analysis below of other of PARC's recommendations relating to investigative procedures.

Another issue that the PPB should address is the absence of any Training Division procedures to implement its new role of conducting administrative investigations of officer-involved shootings and in-custody deaths. The Internal Affairs Division has adopted new procedures (Appendix, page 47) that are good as far as they go, but lack the substantive guidance to its investigators that are provided by IA's procedures for misconduct investigations. A sampling of the topics that could usefully be addressed by a fleshed-out procedure would be:

- How will IA interact with Training on these investigations?
- Which unit will consider whether policies need to be amended or added?
- How will the administrative investigation evaluate compliance with the excellent addition to Section 1010.10 that requires that officers avoid "precipitat[ing] the use of deadly force by placing themselves or others in jeopardy" (Appendix, page 12)?
- What criteria will be used to determine when IA should perform its own interviews and fact gathering?
- When IA decides to interview an officer, should it seek to have a communication restriction order re-imposed? Should it seek postponement of the CISD, or exclusion of that officer from the CISD?
- Will IA investigators debrief the Homicide investigators? Will IA receive all of Homicide's work product?
- When IA re-interviews a witness, will the witness have access to any prior statements?
- Will IA tape its interviews?
- What procedures will be followed if an officer balks at being re-interviewed, or declines to answer a line of questioning?
- What format should the report by IA use?

Recommendation 2005.2: The PPB should promptly draft procedures to govern the administrative investigations by the Training Division concerning officer-involved shootings, in-custody deaths, and injuries resulting in hospitalization, and it should supplement its procedures for such investigations by the Internal Affairs Division so that they are at least as thorough as its procedures for misconduct investigations.

Recommendation 2005.3: PPB policy should make clear that administrative investigations of in-custody deaths and uses of force resulting in hospitalization are mandatory by eliminating the contradictory provisions from Section 335.00 that make them discretionary.

B. Recommendation 4.2: *The PPB should revise its investigative policies regarding firearms discharges at animals and non-injury accidental discharges to require supervisors arriving at the scene to immediately notify the PPB's deadly force investigation unit of the incident. The deadly force unit should either respond to the scene and take over the investigation, or be required subsequently to review the chain of command's completed investigation for completeness and objectivity.*

The PPB has improved upon our recommendation with respect to what it has helpfully renamed "negligent discharges," by requiring that the Detective Division investigate all negligent or unintentional discharges except those occurring at the range, and even then, such discharges must not endanger anyone (Appendix, page 13). The PPB, however, has not followed the portion of this recommendation that relates to discharges at animals, in that the investigation of such discharges remains in the chain of command with no review outside the chain of command, except if a supervisor chooses to seek Detective Division involvement (Appendix, page 13).

II. Officer Sequestration

A. Recommendation 4.6: *The PPB should issue a policy expressly forbidding all officers who participated in or witnessed an officer-involved shooting or in-custody death from discussing the incident with any person (including other involved or witness officers) other than their immediate supervisor, unit commanding officer, union representative, attorney, a medical or psychological professional, and PPB investigators until they have completed comprehensive, taped interviews in the criminal and, if needed, administrative investigations. In discussing the incident with their immediate supervisor or unit commanding officer during this period, officers should provide only that information necessary to secure the scene and identify the location of physical evidence and witnesses.*

Section 1010.10 requires that the Homicide sergeant at the scene of an officer-involved shooting ensure that all involved and witness officers be issued a written communication restriction order before they leave the scene (Appendix, pages 15, 18). A communications restriction order—a copy of which is annexed at page 31 of the Appendix—forbids the served officer from communicating with any but specifically listed types of persons regarding the case in question until the order has been rescinded in writing. The applicable portions of Section 1010.10 and the text of the communication restriction order fully comply with the above recommendation.

B. Recommendation 4.11: *The PPB should memorialize in its policies a rule expressly prohibiting members of the TIC Team—and any other officer not charged with securing or investigating the scene of an officer-involved shooting or in-custody death incident—from discussing the incident with involved or witness officers until the officers in question have submitted to a comprehensive, taped interview with PPB investigators.*

As recommended and in accordance with good practice, the PPB has made clear in Section 1010.10 (Appendix, pages 15-16), the communication restriction order

(Appendix, page 31), and draft procedures applying to the Traumatic Incident Team that neither TIC Team members nor members under a communication restriction order should communicate to the other about the facts of the incident.

C. Recommendation 4.7: *The PPB should issue a policy forbidding all officers from volunteering or communicating any information to involved or witness officers before the deadly force investigation has been completed. In addition, just as a judge may order jurors to avoid media and other discussions of a pending case, so too should the PPB issue a policy directing involved or witness officers to avoid exposure to other accounts of the incident (even if unsolicited) until they have provided investigators with a comprehensive, tape-recorded statement. In addition, the PPB should require its investigators to thoroughly cover in each officer interview what information the officer had received from other officers or outside sources.*

Recommendation 4.7 contains three distinct parts—which have largely been followed.

The first portion of the recommendation calls for a policy prohibiting PPB officers, even if not an involved or witness officer, from communicating any information about the case or investigation to an involved or witness officer prior to the conclusion of a deadly force investigation. Section 1010.10 (Appendix, pages 15-16) imposes such a prohibition while a communication restriction order is in effect. As long as the communication restriction order remains in effect until the investigation has been completed—something which does not always happen because the administrative investigation takes place only after the homicide investigation—the new policy satisfies the first part of this recommendation.

The second part of Recommendation 4.7 calls for a policy directing involved and witness officers to avoid exposure to information from any source about the facts of the

case until they have been interviewed. The first paragraph of the communication restriction order now reads (Appendix, page 31):

> The purpose of this communication restriction order is to safeguard the integrity of the investigation. A thorough investigation based on each individual's independent recall and perception will lend credibility to each member's testimony and the investigation as a whole. In following this theme, it is strongly recommended that you do not review media coverage or other outside information regarding this incident.

The PPB demonstrates forward thinking in adopting this policy. It nonetheless could be improved with two changes in wording. First, the policy would be improved by making it mandatory rather than recommended, as that would better demonstrate the Bureau's commitment to safeguarding the investigation. Second, the final phrase would be provided greater clarity and meaning by the insertion of "receive" before the phrase "other outside information regarding this incident."

The PPB has complied with the final portion of Recommendation 4.7. Section 1010.10 (Appendix, page 18) requires that detectives in deadly force investigations "use the interview checklists, ensuring that all applicable areas are covered." The "Interview outline/checklist: Witness and involved officer interviews related to use of deadly force and in-custody death investigations" includes the following question: "Has anyone discussed the details of this case with you or have you learned information about the incident from sources other that [should be "than"] your own observations?" The question is comprehensive and well-phrased.

D. Recommendation 4.8: *The PPB should require that supervisors arriving at the scene of an officer-involved shooting or in-custody death incident ask each officer at the scene what, if any, discussions regarding the incident have occurred prior to the supervisor's arrival. The supervisor should then brief investigators immediately after they arrive at the scene concerning the answers to those inquiries.*

Detective Division procedures require the assigned Homicide detectives to "identify whom the involved and witness members have spoken to regarding the incident" before the detectives arrived (Appendix, page 34). While implemented by a different Bureau member than we originally recommended, the adopted procedures fully comply with the intent of our recommendation.

E. Recommendation 4.9: *The PPB should require that involved and witness officers be physically separated immediately after the scene has been secured, and that the officers remain sequestered (i.e., unable to communicate with each other) until they have submitted to a comprehensive, taped interview by investigators.*

Section 1010.10 appropriately provides (Appendix, page 16):

> Separation of all witness and involved members is necessary in order to safeguard the integrity of the investigation.

The sequestration requirement is subject, however, to the following exception (Appendix, page 16, 17):

> If the number of individuals to be physically separated is so great to be impractical, a supervisor or detective will be posted to ensure that no communication regarding the incident takes place.

So long as the exception is used only in the unusual cases when the number of involved and witness officers is in fact too many to be physically separated and so long as the number of supervisors or detectives posted to ensure that no communication regarding the incident takes place is sufficient to accomplish the objective, we find the exception to be reasonable.

Section 1010.10 also requires the patrol supervisor on the scene, subject to the above exception, to "[s]eparate all witness and involved members" (Appendix, page 17), and "[w]henever practical," to direct that "each involved member and witness member

should be transported in a separate vehicle" (Appendix, page 20). The supervisor is to assign an uninvolved member to drive each involved member, while witness officers are allowed to drive themselves. While not required by the PPB policy, it is the better practice, when possible, to have involved members transported by supervisors. It is a poor practice, as occurred in at least one of the cases reviewed this year, to have an involved member transported by his patrol partner.

A significant problem lies in the fact that, while involved members are now being interviewed much more promptly, they are not being interviewed before going off duty. Once an involved officer goes off duty, the efforts to separate that officer from any other involved officer and from witness officers end. Again, delay in interviewing witnesses creates risks to the integrity of the investigation process.

Recommendation 2005.4: PPB policy should prohibit involved officers from being transported by their assigned partners and should require, when feasible, that the transportation be done by a supervisor or a detective.

F. Recommendation 4.19: *The PPB should establish policies that ensure that each officer who was involved in or witnessed an officer-involved shooting or in-custody death incident does not participate in a Critical Incident Stress Debriefing (CISD) meeting prior to submitting to a comprehensive, tape-recorded interview in the investigation of the incident.*

As recommended, PPB policies will not permit a CISD meeting prior to all the officers being interviewed by Homicide. Those policies, however, leave it to the Chief's discretion as to whether to prohibit a CISD meeting from taking place until after any Internal Affairs, or potential Internal Affairs, interviews have taken place. As discussed above, the Homicide-and-then-Internal Affairs model the PPB has adopted falls short of good practice. One of the unintended consequences of the decision to choose this model is that the Chief will be put in the position of having to determine on a case-by-case basis

whether to allow the beneficial CISD meetings to occur immediately after the grand jury proceeding or to order officers not to participate in a CISD meeting until Internal Affairs has determined that it has conducted all the interviews it needs for its administrative investigation, which might not occur until three or more months after a deadly force incident. In one 2004 shooting, the Chief in fact ordered the re-issuance of communication restriction orders during the pendency of the IA investigation. This caused the CISD meeting to be cancelled and complaints of disparate treatment by many Bureau officers and the Portland Police Association.

The best solution to resolving the conflict between avoiding tainting officers' accounts before the administrative investigation has been completed and gaining the benefits of a CISD meeting is for the PPB to adopt one of the recommended models for handling these investigations—either the Internal Affairs Overlay or the Specialist Team model. The next-best solution to resolving this conflict between two desirable ends is for the PPB to adopt a policy that delays the CISD meeting until Internal Affairs determines that no further interviews of involved or witness officers will be needed in a particular administrative investigation. The current situation, where the Chief exercises case-by-case discretion, is not an acceptable solution. *Ad hoc* decision-making means there is no policy and no way for PPB members to know what to expect until the Chiefs (whoever they may be) rule. Moreover, to the extent the Chiefs allow CISD meetings to precede IA interviews, the PPB's practices will be inconsistent with good practice.

III. Interviewing Involved Officers Contemporaneously

Recommendation 4.3: *The Bureau should revise its policies to make clear that investigators should always strive to obtain a contemporaneous, tape-recorded interview of involved officers. Such a policy would not only ease doubts about officer collusion, but place officers and civilians on the same footing. In addition, in those cases where an officer declines to provide a contemporaneous interview, investigators should be required to thoroughly document their efforts to obtain the interview, including (1) when*

the request was made, (2) to whom it was directed, and (3) the reason(s) for the declination.

Recommendation 4.4: *The PPB should meet with the leadership of the police unions to work out procedures for taking voluntary statements from involved officers in the hours immediately following a shooting or in-custody death incident. Interviews would not be conducted until after the officers have been given an opportunity to consult with a lawyer and/or union representative. The unions should encourage involved officers to provide investigators with contemporaneous statements, and likewise should encourage the lawyers they furnish to their members to facilitate such prompt statements.*

Recommendation 4.5: *The PPB should study the Phoenix system of obtaining contemporaneous statements, in which all involved or witness officers are ordered to speak to Internal Affairs investigators no later than a few hours after the deadly force or in-custody death incident, regardless of whether they have already given a voluntary statement to Homicide investigators. The IA interview, which is walled off from Homicide and the District Attorney, is used solely in connection with the agency's administrative and tactical review of the incident.*

The PPB has fully complied with Recommendations 4.3 and 4.5, and it has taken significant steps toward compliance with Recommendation 4.4. Preceding the issuance of the PARC Report, involved officers were not interviewed until three or more days after a deadly force incident. Those delays sometimes stretched to five or six days in the absence of any exigent circumstances, such as an officer being hospitalized, that would justify such lengthy delays. Since the issuance of the PARC Report, with one reported exception, Homicide has been interviewing involved officers within approximately 24 hours, which is a substantial improvement from prior practice. We nonetheless have two concerns.

The first concern is that even the delay of 24 hours allows officers to leave sequestration and thus to become subject to improper outside influences on their

statements. While collusion between officers to tailor their statements is prohibited by the communication restriction orders, the opportunity to do so exists once officers are no longer separated. Even the delay of 24 hours creates a risk of collusion or other improper influences that would not exist if statements were taken before an involved officer went off duty. Moreover, the less justified the officers' conduct the greater the incentive to risk the consequences of violating a communication restriction order. If officers believed they were likely to be criminally prosecuted or dismissed from the force for an out-of-policy shooting, they would be unlikely to be deterred by the consequences of violating a communication restriction order. We thus recommend that the PPB continue to work toward devising procedures for interviews of involved officers before they go off duty, as occurs, for example, in Phoenix (see PR pages 59-60).

Some might disagree with this concern on the ground that it appears to assume that involved officers are untrustworthy or potential criminals, thereby impugning the integrity of officers who shoot a suspect. This is not so. Rather, members of the community are more inclined to presume good faith on the part of a police department investigating its own officers if the appearance and reality of the integrity of the investigation are patent.

The second concern is that the progress the PPB has made in lessening the delay in involved officers' interviews from three or more days to one day is based solely upon informal understandings with the Portland Police Association. No binding agreements have been reached. There is nothing that officially prevents the union from reverting to advising involved officers to delay their interviews for days. Several people we interviewed characterized the current willingness of the union to encourage its members and their lawyers to submit to interviews within 24 hours as the product of public pressure. The union, it was said, recognized that it was in its self-interest to bend on this issue to achieve other goals that it deemed important. But, it was warned, the fading of public pressure stemming from controversial shootings over the past several years might well result in a reversion to delays of several days. Several people we interviewed also pointed to the union's accommodations on this issue as being based on personal

relationships. People cautioned that a change of personnel in either the union leadership or in certain positions at the PPB could cause a reversion to the delays of three or more days. The PPB thus must continue to work to devise procedures that will ensure that contemporaneous interviews of involved officers will occur as a matter of binding procedures.

IV. Interviews

A. Recommendation 4.12: *The PPB should revise its deadly force policy to ensure that all persons who witnessed an officer-involved shooting or an in-custody death are interviewed on tape by investigators. The PPB should specifically eliminate its policy granting Homicide the discretion to forego interviews of witness officers and rely instead on written reports. Transcripts of all interviews should be included in the case file.*

Recommendation 4.13: *If a civilian refuses to submit to a taped interview, investigators should (1) not begin the interview until the witness has signed a form acknowledging that he or she has refused to be interviewed on tape; and (2) present the civilian with a written copy of the investigator's summary of the interview and allow the citizen to review and sign the investigator's summary for accuracy. The civilian should be permitted to make any corrections or amendments to the statement he or she feels is necessary. A copy of both the original and corrected/amended witness summary should be included in the investigative file.*

Recommendation 4.15: *The PPB's policy and practice of conducting untaped "pre-interviews" of officers or civilians should be eliminated.*

Section 1010.10 provides (Appendix, page 18): "All interviews [of witness and involved members] wherein material facts of the case are discussed will be tape-recorded in their entirety." The policy also provides that detectives' responsibilities include (Appendix, page 18): "Interview civilian witnesses and attempt to tape-record their

statement." Pre-interviews of both PPB members and civilians have been eliminated. Detectives are required to include transcripts of all taped statements in the case files (Appendix, page 18). The Detective Division's procedures further require the tape recording of all interviews (Appendix, page 34). These provisions represent a significant and appropriate improvement in response to the PARC Report.

While the policies and procedures require that all interviews of PPB members be taped in their entirety, we have a small concern that in practice some preliminary procedural matters are covered before the tape is turned on. While this may not present a problem generally, it does run the risk of an inadvertent failure to tape something of significance before the tape has been activated. The better practice is to tape the entire interviews including all preliminary and procedural matters.

Turning to Recommendation 4.13, the PPB has thus far not followed that recommendation. While virtually all civilians agree to taped interviews, a small percentage does not. The PPB has told us that it cannot produce a copy of the investigator's summary of an untaped interview immediately and it fears that civilian witnesses will change their statements between the time they provide those statements and the time the witnesses are asked to come back to approve the investigator's summary. The PPB's concern is legitimate. Some witnesses may want to change their statements when they are asked to approve the summaries. Notwithstanding the PPB's legitimate concern, we adhere to our recommendation because the concern that prompted this recommendation overrides the PPB's concern. When we were preparing the PARC Report we found investigator summaries of *taped* interviews that did not accurately or fairly represent what the witnesses had said on tape. Our concern about the accuracy and fairness of the summaries and the need for civilians to verify that they said what is in the summaries is thus not a hypothetical concern.

The consequences that may result from not asking a witness to approve the summary of his untaped statement are considerably greater than the consequences that may flow from providing a witness with that opportunity. If a witness recants (which he

can do at the grand jury or an inquest whether or not asked to approve a summary of his statement), two detectives will be available to testify to the witness's original statement. If, on the other hand, a detective distorts a summary of an untaped statement, that distortion is unlikely to be discovered in the administrative review performed by Internal Affairs and Training, as IA will generally interview very few witnesses on its own and Training will interview none. Weighing the competing risks supports Recommendation 4.13. The PPB should follow the recommended procedure, just as the police department in Washington, D.C. does. See PR 70 note 94; PR Appendix page 162.

Moreover, the PPB can both follow Recommendation 4.13 and also avoid most of the risk of recantation by writing up the summaries—in handwriting, if necessary—before the witness leaves the building. Such quick turnarounds are done every day for suspects' confessions. Such prompt production of summaries seems eminently doable for the very few statements taken where a witness declines to be taped.

B. Recommendation 4.14: *PPB investigators should video- or tape-record all scene walk-throughs with involved or witness officers. Transcripts of all walk-throughs should be included in the case file.*

The PPB has renamed what it used to call a "walk-through" an "on-scene briefing." By either name the process is one by which a witness officer gives investigators a brief account of what happened and where, to assist in gathering evidence and otherwise processing the scene appropriately. Based upon the summaries of the walk-throughs in cases reviewed for the PARC Report, it was clear that sometimes witness officers (and occasionally involved officers) provided detailed oral statements concerning the incidents. In a step in the right direction, the PPB has now directed detectives to restrict the detail provided to what is required for purposes of processing the scene. To date, however, the PPB has not adopted this recommendation.

Even if carefully restricted in scope in actual practice, the absence of a tape will preclude the best evidence of any inconsistent statements an officer might make. The PPB objects to Recommendation 4.13, above, because of a fear of recantation by civilians. Concern about recantation by officers—which can also happen—should cause the Bureau to adopt this recommendation.

C. Recommendation 4.16: *The PPB should improve the already useful existing Deadly Force Interview Checklist by adding policy and tactical questions, including:*

(1) Whether the officers can think of

(a) Alternative approaches that might have minimized risk to themselves and others, and

(b) Potential improvements in PPB training;

(2) A description of when and why the officers decided to

(a) Draw their guns;

(b) Point their guns; or

(c) Lower or re-holster their guns;

(3) Describing the grip and shooting stance used by the officers, including gun/flashlight technique;

(4) Indicating whether the shots were sighted;

(5) Describing the availability and use of cover and concealment; and

(6) Identifying distances from suspects with weapons other than guns, and opportunities for tactical retreat.

Recommendation 4.17: *The PPB should also issue a policy requiring investigators to cover all areas on the modified interview checklist in all interviews.*

Recommendation 4.18: *The PPB should prepare an Interview Checklist, similar to the Deadly Force Interview Checklist, to be used during in-custody death and serious force investigations.*

All of these recommendations have been followed. The PPB's deadly force interview checklist was an impressive and useful document even before the additions proposed by Recommendation 4.16 were made. The checklist (Appendix, page 43) is excellent. One suggested improvement would be to require questioning in appropriate cases concerning the existence of opportunities for tactical retreat.

With respect to Recommendation 4.17, Section 1010.10 (Appendix, page 18) appropriately requires the use of "interview checklists, ensuring all applicable areas are covered" in the interviews of involved and witness officers.

With respect to Recommendation 4.18, the PPB has added "in-custody death investigations" to the subheading of the checklist and has added a useful section devoted to such investigations to the list (Appendix, pages 43, 45).

V. Management of the Scene

Recommendation 4.10: *The PPB should memorialize in its policies the requirement that members of the TIC Team—and any other officer not charged with securing or investigating the scene of an officer-involved shooting or in-custody death incident—remain outside of the crime scene absent express authorization from on-scene PPB investigators.*

PPB Manual Section 640.10 directs that the first member present at a crime scene should "[e]xclude all unauthorized persons (all persons who do not have an official duty to perform pertinent to the incident should be kept out of the protected crime scene)." Policy 640.10 complies with the general portion of Recommendation 4.10, but it does not address TIC directly. However, draft procedures for Employee Assistance Program ("EAP") members, including TIC, direct them "to respect crime scene integrity and wait to be directed into the scene if necessary by the crime scene supervisor." The PPB informs us that TIC members are now kept out of crime scenes because they are

"unauthorized persons" within the meaning of Section 640.10. Section 640.10, coupled with the draft EAP procedures, complies with Recommendation 4.10.

VI. Civilian Oversight of Administrative Investigations

Recommendation 5.15: *The City of Portland should create an independent, professionally staffed, and adequately funded mechanism for civilian oversight of PPB investigations of administrative issues and analyses of tactical decisions arising out of officer-involved shootings and in-custody deaths. At a minimum the oversight mechanism would monitor:*

- *(a) Crime scene processes and procedures (this would involve rolling out to the scenes of officer-involved shootings and in-custody deaths);*
- *(b) Evidence collection and preservation;*
- *(c) Witness identification and interviewing;*
- *(d) Investigative file integrity and preservation; and*
- *(e) Presentation of evidence to the Review Level Committee.*

This important recommendation, designed to ensure the thoroughness and fairness of administrative investigations, is directed to the City of Portland, not the PPB. To date, the City has taken no action on this recommendation. Our findings in Chapter 5, Section I, below, with respect to the incomplete and biased investigations conducted in 2000 and 2001 strongly reinforce the reasons upon which this recommendation was originally based. See PR 126-27. The City has recognized the value of civilian oversight of Internal Affairs investigations of police misconduct. Cases where a life was taken or could have been taken deserve as least as much oversight, particularly since the PPB investigations conducted from 1997 through 2001 were consistently incomplete and/or biased.

Since the PARC Report was issued, Denver, a city similar in size to Portland, has created an Office of the Independent Monitor that will provide oversight for

investigations into officer-involved shootings, in-custody deaths, and cases where police uses of force result in death or serious physical injury. (The authorizing ordinance may be found at http://198.202.202.66/PoliceComplaints/template320090.asp.) Among other things, the ordinance seeks to have the monitor have access to the scenes of officer-involved shootings and in-custody deaths, witness interviews, and other evidence, as the investigation of these incidents proceed. Los Angeles County has created a similar model in the Office of Independent Review, which monitors investigations of serious force incidents involving the Los Angeles County Sheriff's Department. See http://laoir.com/report1.pdf, pages 11-15. Perusal of the findings set forth in Chapter 5 of the PARC Report and in Chapter 5, Section I (pages 65-70) of this Report demonstrates the need for such oversight in Portland.

4. Incident Reviews: Tactics and Risk Issues

For this report, PARC reviewed 14 officer-involved shootings occurring between July 1, 2000 and December 31, 2001 to identify policy issues and patterns that the PPB should address. Consistent with the City Council ordinance authorizing this study, PARC did not re-investigate these 14 cases nor attempt to reach conclusions whether individual shootings were justified. Rather, our review was calculated to make observations and draw lessons that will assist the PBB to devise better tactical and strategic options for its officers, improve the quality of supervision, avoid unnecessary shootings, and better investigate and review deadly force incidents. In this chapter, we discuss risk management and tactical issues raised by the 14 cases. In Chapter 5, we discuss the issues raised by the cases that relate to the internal PBB investigation and review of the shootings.

As noted in the Introduction, the shootings and the investigations in the 14 cases we reviewed for this report all occurred at least 20 months *before* the PARC Report was issued in 2003. Thus, there is no expectation on our part, and should be no expectation on any reader's part, that what occurred in these cases could have been influenced by the PARC Report's recommendations. Nonetheless, each of these cases provides opportunities to learn lessons for the future.

Police work is inherently dangerous. The rare situations that threaten officers' lives or the lives of others are interspersed among countless day-to-day interactions with the law-abiding public and with lawbreakers who pose no threat. In a small number of those dangerous situations, officers will have no good option but to use deadly force. The risks arising from police operations are not, however, entirely unpredictable or random. Although danger to officers is unavoidable, and officer-involved shootings, to some degree, are also, careful risk management will minimize the frequency with which officers resort to deadly force.

In this year's review, we identified four areas where the PPB could improve its performance in the area of deadly force.

1. Critical Incident Management. Among other things, we found instances where supervisors should have been on the scene but were not, or were there but failed to take charge or communicate vital information to line officers.
2. Extracting Persons from Vehicles. We encountered situations where officers exercised substandard tactics and strategy when attempting to get individuals out of their cars and trucks after a traffic stop or a pursuit.
3. Police Encounters with Individuals in a Disturbed Mental State. We discovered cases involving inadequate training, questionable tactics and strategy, or poor supervision.
4. Rendering Aid to Wounded Persons. There were instances where officers could have safely rendered first aid, or allowed medical personnel to provide treatment, but did not.

By contrast, the PPB employed effective tactics in several cases we reviewed, such as where it promptly created a containment that led to the identification and apprehension of the person who had recently committed an armed robbery, and where it employed a radio tracking device to identify robbers and to effectively pursue their car and apprehend them.

In each instance where the PPB's performance fell below good practice, the chances of an officer or civilian suffering harm increased. This does not mean that these lapses in and of themselves caused otherwise avoidable injuries or deaths. So many variables affect the outcome that such judgments typically cannot be made with any degree of assurance: Would a gun-toting suspect who was confronted in a poorly-managed police operation been shot in any event even if a well-managed strategy had been employed? Would a knife-wielding subject who was shot with a firearm have been effectively subdued if a less-lethal weapon had been deployed? In most cases, one can only speculate whether a lethal outcome *would* have been avoided.

Unsatisfactory performance does, however, raise the question of whether a more favorable outcome *could* have been achieved. Although it may not be possible to say, case-by-case, whether death or injury was truly avoidable, it is undoubtedly the case that sometimes the answer to that question will be "yes." Substandard performance in managing the risk of deadly force, therefore, invites avoidable trauma, pain, and grief for officers and civilians alike.

I. Critical Incident Management

Critical incidents—situations of potentially life-threatening danger to police officers or members of the public—demand a skillful, deliberated, tactically sound police response. A police department that consistently does so will have gone a long way towards eliminating avoidable uses of deadly force and frayed community relations.

While critical incidents like terrorist bombings are a rare occurrence, others—such as the cases we reviewed—constitute relatively routine police work. When officers have no option but to react immediately to a rapidly unfolding incident, the opportunity for consideration of alternatives is limited. In some of the incidents we reviewed, officers had to make split-second decisions in response to immediate deadly threats. Yet in seven of 14 cases, the officers had advance indication of real danger and thus had time to consider alternatives and adopt sound tactics and strategy. In these cases, the involved officers, to varying degrees, failed to do so, thereby unnecessarily jeopardizing their own safety as well as that of bystanders and suspects.

Consideration of officer-involved shootings entails much more than simply questioning whether officers had a plausible justification for pulling the trigger. Rather, one must conduct a step-by-step analysis from the first moment the Bureau was notified that something potentially dangerous was unfolding. One must then critically examine the actions and omissions of all those personnel who became involved, or whose involvement should have occurred but did not, through to the incident's conclusion.

A. Planning

Whenever police officers have the opportunity to formulate a well-considered plan before taking action, they should take full advantage and do so effectively. To do otherwise is to virtually guarantee a sub-optimal response to whatever challenges an incident might present. In 10 of the 14 incidents we reviewed, additional planning would have been appropriate, as illustrated by the following examples:

1. Taking account of risk factors

- An officer left a probationary officer alone with an agitated, mentally-disturbed man. The inexperienced officer then physically confronted the agitated individual, further upsetting him.

2. Assembling sufficient police resources before taking action

- A sergeant and officers tried to remove a barricaded suspect who had threatened the use of deadly force from a dwelling without obtaining the proper equipment and without notifying the Special Emergency Reaction Team ("SERT"), as was apparently required by PPB policy.
- An officer conducted a solo foot pursuit and confronted a suspect alone even though the reason the officer thought the suspect was fleeing from a traffic stop was that he might have a gun.

In each instance cited here, better planning could have enhanced officer safety and reduced the likelihood that officers would need to use their weapons in self-defense.

B. Communication

Effective communication is an essential element of any well-managed police operation. Our review identified failures in communication as problematic in five cases.

Ineffective communication by officers can make it difficult for supervisors to take control and coordinate and direct officers at the scene. Likewise, communication failures by supervisors can produce suboptimal performance in the field. These issues are demonstrated in the following examples:

1. Alerting colleagues to danger

- An officer did not inform colleagues that the suspect was armed with a knife.

2. Supervisors communicating tactical instructions

- A sergeant who broadcast a report of a "man with a gun" did not coordinate officers' response to his broadcast and, even when on the scene, did not communicate with the officer who was about to confront the man with a gun.

3. Communicating key tactical decisions

- An officer did not communicate with his partner how the first officer and others on the scene were planning to contain and isolate an agitated subject.
- An officer did not communicate to his partner that he suspected the man they had just stopped for questioning was the armed robbery suspect they were looking for and that he (the first officer) was about to take the man into custody.

C. Field Supervision

Our review identified six cases where substandard supervision caused or contributed substantially to a poor outcome. Indeed, overall, supervision problems were a particularly critical weakness in the cases we reviewed. Effective supervision leads to better outcomes. For example, the San Diego Police Department has found that getting a supervisor to the scene of a critical incident reduces the chance of an officer-involved shooting by 80 to 90 percent. Police Executive Research Forum, *Chief Concerns:*

Exploring the Challenges of Police Use of Force, page 10 (April 2005). Experience from the San Jose Police Department also suggests that more effective supervision was the prime cause in a steep reduction in officer-involved shootings. See PR 175, note 182. An effective field supervisor is alert at all times to his or her officers' activities, and seeks to actively manage the police response to any incident that is life-threatening or that requires the coordination of multiple officers' actions.

The PPB should seek to ensure that all supervisors are equipped with the requisite skills and knowledge to effectively command their officers whenever a critical incident arises. As Chief William Lansdowne has noted, the San Diego Police Department has trained its sergeants who are responding to critical incidents "to work as a team, to slow things down, and accept the responsibility of doing this work safely." Police Executive Research Forum, *Chief Concerns: Exploring the Challenges of Police Use of Force,* page 11 (April 2005).

The following are examples of problematic supervisory performance identified during our review:

1. Supervisors issuing tactical instructions

- Supervisors on the scene issued no instructions to officers as to what they should do if the suspect was not disarmed by use of a less-lethal weapon.

2. Supervisors assuming a supervisory role

- Instead of taking a leadership role, a supervisor responding to a "man with a gun" call gave no directions to a subordinate officer and left him to confront the suspect alone.
- A sergeant on the scene did not accompany officers under his supervision when they went to confront a dangerous suspect.

3. Supervisors overruling inappropriate strategies

- Although terminating his own foot pursuit of an armed suspect at night because he knew it was unduly dangerous, a sergeant failed to stop a subordinate from continuing his foot pursuit of the suspect.

II. Extracting Persons from Vehicles

In three cases, unarmed drivers were shot as they tried to escape from police custody after having been stopped for a traffic infraction. In two instances, contrary to longstanding PPB training, officers leaned through the window of the vehicle, placing themselves in a vulnerable position, particularly if the car was put in motion. In two instances, a single officer, acting alone, tried to extract a driver from a vehicle or to stop him from driving away.

Extracting uncooperative, but unarmed, individuals from vehicles led to several officer-involved shootings reviewed in the PARC Report, three officer-involved shootings in the 18-month period under review in this report, and two highly controversial shooting incidents in 2003 and 2004. In response to the latter incidents, the PPB expanded its training curriculum on vehicle extractions and made it part of mandatory in-service training for all officers.

The recently instituted training curriculum focuses on distraction techniques and control holds that are designed to get the occupant out of the vehicle, while protecting officers and avoiding putting them into situations where the use of deadly force might become necessary. Alternative options presented in the training to the various control holds are using a Taser or pepper spray, or getting the subject to hand an officer the ignition keys. Officers are appropriately taught, as they have been in the past, never to reach or lean into a vehicle. We question the fact, however, that, with the exception of

one tactic, the training does not require that more than one officer be present and involved in attempting a vehicle extraction.

Precisely because extracting uncooperative persons from vehicles is so potentially problematic, such situations demand planning and effective, thought-out tactics. As a threshold matter, officers need to ensure their own safety by positioning themselves as safely as they can alongside the vehicle in a position that makes it harder for an occupant of the vehicle to try to use a weapon against them. Assuming the occupant(s) do not pose an overt threat to the officers or others, the officer(s) on the scene should treat the situation as one of containment—i.e., they are seeking to contain the person in the vehicle until the occupant exits or is safely extracted from the car. Once several officers are on the scene, spike sticks, or other devices that will puncture the vehicle's tires, can be placed in front of and behind the vehicle so as to prevent the car from being driven too far.

A supervisor should be notified and be on site before any extraction is attempted. The supervisor should be in charge of planning how to extract the individual and how the police personnel should be deployed. The presence of a supervisor is a factor that experience has shown lessens the likelihood of the use of deadly force. See pages 51-52, above. Forcible extraction of a person from a vehicle is a critical incident that demands active supervision. The frequency of PPB officer-involved shootings arising out of these circumstances from 1997 to 2004 alone demonstrates the necessity of a strong supervisory presence.

Officers should not be in a hurry to extract the person from the vehicle. The mere passage of time, combined with the person's increasing awareness that he is seriously outnumbered and has no reasonable likelihood of escape, will cause many recalcitrant individuals to think better of their refusal to comply with the officers' directives. With time on the police officers' side, supervisors can plan a safe extraction. These tactics are designed to get the individual out of the vehicle with the minimum force necessary, while not compromising the safety of the officers.

Recommendation 2005.5: PPB procedures should require (a) that a supervisor and sufficient cover officers be present before members try to extract an apparently unarmed person from a vehicle, and (b) that tactics calculated to protect the safety of both the officers and the occupant of the vehicle be employed.

III. Police Encounters with Individuals with Mental Illness, Emotional Disturbance, and Suicidal Ideation

Our review included five instances where PPB members encountered individuals with mental illness or severe emotional disturbance, or persons actively pursuing suicide. The proportion of incidents in which these issues arose this year was double the proportion of such cases in the 1997 to mid-2000 period covered by the PARC Report: five of 14 incidents (36 percent) this year as compared to six of 34 incidents (18 percent) analyzed by the PARC Report. In four of the five cases reviewed for this report, the police officers knew of the subjects' mental illness, emotional disturbance, or suicidal ideation ("disturbed mental state" hereafter) before the confrontation that led to the shooting began. In the fifth case, more would have been known about the subject's emotional state had the officers who responded more fully debriefed the civilian on the scene who had summoned the police.

Police encounters with subjects with disturbed mental states involve great unpredictability and risk to both law enforcement personnel and the subjects involved. Many police departments, like Portland, have therefore put together specialized teams to deal with persons in a disturbed mental state. In the PPB, the team is called the Crisis Intervention Team ("CIT"). CIT officers receive specialized training in dealing with individuals with disturbed mental states and learn to slow down and de-escalate incidents, negotiate with subjects, and respond more flexibly.

Approximately 140 of the PPB's current officers have received CIT certification, which is a decrease from approximately 200 when the program started. Even with the

higher number of CIT-certified officers in 2000-01, less than half of incidents identified as appropriate for CIT were responded to by CIT-certified officers. In 2004-05, however, the Bureau has added a mandatory two-hour CIT/Mental Health Awareness component to the in-service training for all sworn members. While the two-hour awareness training cannot substitute for the 40-hour certification training, the training of CIT officers and the mandatory CIT Awareness training are both excellent steps to help the Bureau deal with this complex and difficult issue that challenges all police departments. Were government at all levels to better address the problems of those with mental illness, law enforcement personnel would less frequently be called upon to deal with problems resulting from a lack of sufficient governmental commitment and resources.

In none of the five shooting cases reviewed this year involving subjects in a disturbed mental state was the involved officer CIT-trained. In three of the five cases, Bureau personnel knew from the time the call was received that the subject was experiencing a mental disturbance. In four of the five cases, the timing of the confrontation with the subject was in the control of the police. Because there was no immediate danger to another person in those four incidents, the police could have employed de-escalation and other CIT techniques. In the fifth case, the officers should have first sought to rescue the suspect's relative, thereby isolating the suspect. The officers would then have had control of the timing of any subsequent confrontation.

In the PARC Report (pages 204-06), we pointed out the success of the Memphis CIT model after which Portland's Crisis Intervention Team training is patterned. Just as supervisors should be dispatched to every critical incident where there is a substantial risk of deadly force, so too should at least one CIT officer be dispatched to every incident where the subject is known to be in a disturbed mental state. To do so will require a significant increase in the number of CIT-certified officers.

Cincinnati Police Department Procedure Manual 12.110 (March 9, 2004) (a copy of which is set forth at Appendix page 51) provides a model that Portland could beneficially follow:

> Mental Health Response Team (MHRT) officers will be the first responders, when available, on all runs involving suspected mentally ill individuals. If two MHRT officers are available, they will be dispatched as a team. If the run is an emergency and no MHRT officer is available, beat cars will be dispatched immediately and an MHRT officer from another district will be notified to respond. If the run is **not** an emergency and no MHRT officer is available, the nearest MHRT officer from an adjoining district will be dispatched as the primary car.
>
> An MHRT officer on the scene of a suspected mentally ill individual will be the primary officer handling the situation. They will also be responsible for transporting the individual, if necessary, to the hospital.
>
> A supervisor will respond on all radio runs involving violent or potentially violent mentally ill individuals and when possible, will consult the MHRT officer on scene to decide on a course of action. [Emphasis in original.]

And the Denver Police Department Operations Manual 105.00 (4)(d)(2) (August 2004) (a copy of which is included at Appendix page 58), in discussing "use of force/control options" provides:

> **Requesting a CIT officer:** Whenever an officer learns, through his or her observations or otherwise, that a person with whom the officer is dealing may be a mentally ill, developmentally disabled, or emotionally disturbed individual, the officer will, if time and circumstances reasonably permit and dictate, contact dispatch and request that a CIT officer respond to the scene. If time and circumstances reasonably permit, officers will use distance, time, verbal tactics, or other tactics, to de-escalate the situation when dealing with such persons. When a CIT officer arrives on the scene, he or she should be the primary officer responsible for coordinating negotiations with the mentally ill, developmentally disabled, or emotionally disturbed individual unless determined otherwise by the CIT officer or a superior officer.

That none of the approximately 1,300 responses by CIT-certified officers to incidents involving persons with disturbed mental states in the 18 months under review resulted in an officer-involved shooting strongly suggests the value of the training. Since universal CIT certification should lessen the overall number of officer-involved shootings, the cost of certifying all PPB officers as CIT officers would be at least

somewhat offset by the money saved from not having to deal with the consequences of those avoided officer-involved shootings.

The Bureau has a valuable resource in its CIT-certified officers, and it should use them whenever possible when dealing with persons in a disturbed mental state. The volume of such cases means that the Bureau will have to train more CIT officers. Nationwide, as in Portland, the number of such cases continues to increase. The PPB's requirement that all sworn members receive in-service training on CIT/Mental Health Awareness is commendable. It is an important step toward decreasing incidents where officers might otherwise resort to deadly force against persons with mental and emotional problems. The Bureau should nonetheless analyze the desirability of providing all officers with CIT certification and, if that is determined to be too costly or otherwise not feasible, it should ensure that it trains enough officers in CIT techniques and has an adequate number of CIT-certified officers available on every shift for rapid deployment.

In one case we reviewed, the staff of a mental hospital twice called police officers to deal with a patient who, though agitated, was not engaging in criminal conduct. The incident ended with the fatal shooting of the agitated patient. The man died as a result of the hospital's failure to manage its patient. Mental health facilities have a responsibility to capably deal with run-of-the-mill agitation and physical resistance by their patients. Their staff should be trained and their facilities equipped to cope with such problems without police intervention. The presence of the police in this incident escalated the man's agitation, increasing the likelihood of a physical confrontation.

The second time the hospital called the police on the evening in question, all the patient had done was to walk out of an isolation room with a faulty lock. The Portland Police Bureau should not have had to respond to that call (or the earlier one) from the mental hospital. Dealing with garden-variety management of agitated patients is the responsibility of the hospital and its staff, not armed police officers who have not been trained to control persons with mental illness, particularly in a hospital setting. The PPB should have had a protocol in place that barred response to mental hospitals for routine

patient management issues unless serious criminal conduct had been committed or threatened—a threshold not approached in the incident in question.

We understand that the PPB is currently working on a protocol with Multnomah County governing when the police will respond to mental health facilities having problems managing unruly patients. The protocol should prohibit PPB response to routine patient management situations. To the maximum extent possible, the PPB should put every mental health facility in the City of Portland on notice that it is inappropriate for police officers to respond to routine patient management situations and that the facilities have the responsibility of managing such situations without police assistance. When serious criminal conduct has occurred or is threatened, however, the police should respond. In such circumstances at least one CIT-certified officer should be dispatched to the facility even if that officer will not be the first on the scene. Because serious criminal conduct by a person with mental illness is a critical incident, a sergeant should be dispatched to all such calls. Officers dispatched to mental health facilities should be appropriately equipped with a range of less-lethal weaponry.

Recognizing the volume of inappropriate calls for police assistance from mental health providers, the PPB is also proactively working with the City Bureau of Emergency Communications and the providers to try to lessen the number of unnecessary calls for police assistance.

Recommendation 2005.6: The PPB should develop a policy that prohibits it from responding to routine patient management situations in mental health facilities, and the Bureau should advise all mental health providers in the City of Portland of that policy.

IV. Rendering Aid to Wounded Persons

Just as the Portland Police Bureau's reverence for human life should limit its use of deadly force to situations when no other alternatives are reasonably available, so should that reverence for human life require that the Bureau as soon as safely possible render medical aid to suspects who have been injured. It is not a Hobson's choice between rendering or obtaining medical assistance and officer safety. Officers should provide emergency aid to a wounded person, or obtain it, unless the circumstances clearly demonstrate that to do so would unreasonably endanger the officers. Not only is such a requirement consistent with a reverence for human life, but it also demonstrates to members of the community that the Bureau adheres to that value.

The failure to assist a seriously wounded suspect when it was safe to do so necessarily will upset the community. The more controversial the shooting, the greater the likely outrage. If the circumstances suggested that the unreasonable withholding of emergency medical aid resulted in the wounded person's death, the officers involved—and the Bureau by extension—could justifiably be accused not only of a lack of reverence for human life, but also of a callous disregard for human life.

Three of the 14 cases we reviewed demonstrated withholding of medical aid following a shooting for varying lengths of time ranging from several minutes to an hour and a half. In each circumstance analysis of the facts showed that medical aid could have been rendered more promptly without unreasonable risks to officer safety.

The 90-minute delay occurred in the following circumstances. After an unsuccessful effort to pull the suspect driver out of his minivan, an officer shot him when he put the vehicle in gear. The officer saw that the bullet had entered the suspect's torso, heard him groan, and saw him fall over between the driver's and passenger's seats. The autopsy suggests that the suspect, whose aorta and heart were pierced by the bullet, probably died instantly, but that was not known at the time. Within several minutes medical aid and SERT were called for.

Other than the driver, there was no one else in the minivan, as the second occupant was known to have fled before the shooting. Neither occupant of the minivan had displayed a weapon during the incident. After the shooting two officers climbed onto a nearby roof and could observe the suspect lying face down between the seats, not moving, although they could not see his hands. The officers who responded to the scene moments after the shooting spent an hour and a half pointing their guns at the stationary minivan. They did so even though approximately halfway through the period of delay, a detective wrote that officers "thought that the individual inside the van was most likely deceased." After an hour and a half the vehicle was "cleared" and the suspect's body recovered. Emergency medical technicians then determined that the suspect was dead.

As part of its recent re-evaluation of its policies relating to deadly force, the PPB initiated policy changes relating to the rendering of medical aid. The Bureau is to be commended for initiating the policy changes relating to subjects who are or might have been injured, particularly because the topic of rendering aid to wounded persons was not raised in the PARC Report. The cases we reviewed from 2000 and 2001 cause us to make additional recommendations.

Section 1010.10 (Appendix, page 15) adds a new subsection to the policy entitled "Post Use of Force Medical Attention" which states:

> When a person has been injured by the use of force by a Bureau member or there is a potential for injury to that person a member shall continually monitor the subject, if tactically feasible or appropriate. EMS will be requested to respond if the injury requires medical attention. The member shall monitor the subject for changes in their skin color, breathing and levels of consciousness. If any significant changes in any of these areas are observed, the member shall notify EMS immediately. See DIR 630.50 for further requirements.

PPB Manual Section 630.50 requires that members "provide medical aid to ill or injured persons" when they have been properly trained and certified and when:

c. Primary police duties have been accomplished.
    1. Any immediate danger has been neutralized.
    2. Dangerous subjects have been apprehended or have fled the immediate area.
    3. Any required emergency assistance has been requested by telephone or radio, at the earliest time feasible.

Also, Section 640.10(c) was amended in 2004 to require the first officer on the scene to "render aid," as well as "[p]rotect human life."

Exactly how the quoted portion of Section 630.50 relates to the newly drafted portion of Section 1010.10, particularly its "tactically feasible or appropriate" requirement, is not readily apparent. The PPB should harmonize its policies to make explicit that medical aid should be sought for and rendered to injured persons as soon as possible unless the circumstances clearly demonstrate that to do so would unreasonably endanger the officers or medical personnel.

In the cases we reviewed the investigations did not examine the question of whether medical aid had been rendered in a timely fashion. Without such inquiries during the investigation, the review body—now the Use of Force Review Board—will not have the information it needs to determine whether a delay in rendering or obtaining medical aid was reasonable.

The policies relating to the administrative investigation by Internal Affairs should be amended to require inquiry, in all cases where a person was shot or otherwise seriously injured, as to whether medical aid was obtained and rendered without unreasonable delay. The policies relating to the Use of Force Review Board should be amended to require an explicit determination, in all cases where a person was shot or otherwise seriously injured, as to whether the obtaining and rendering medical aid complied with the PPB's policies. Investigating and reviewing this issue will increase accountability, provide guidance to supervisors at the scenes of shootings, and help determine whether the policies and training that exist concerning this subject are appropriate and sufficient.

Recommendation 2005.7: The PPB should clarify its policies relating to medical attention and rendering aid to make clear that officers who have used deadly force are required to ensure that medical aid is rendered to injured persons as soon as possible, unless the circumstances clearly demonstrate that to do so would unreasonably endanger the officers or the medical personnel.

Recommendation 2005.8: The PPB should promulgate the policies and procedures necessary to require in all instances of the use of deadly force where a person is seriously injured: an Internal Affairs administrative investigation, and an explicit determination by the Use of Force Review Board, as to whether there was compliance with the policies for ensuring that medical aid is appropriately and timely rendered.

5. Incident Reviews: The PPB's Investigations and Review

I. Quality of Homicide Investigations

In Chapter 5 of the PARC Report, we discussed in some detail the ways in which homicide investigations and reports were in need of improvement. Among the areas of concern identified were the following:

- Not all relevant witnesses were interviewed and many interviews, both with officers and with civilians, were not taped.
- Interviews often were not thorough and were too narrowly focused on the moment when deadly force was employed.
- Questions during interviews were often leading and/or biased.
- In many instances attempts were not made to pursue or resolve inconsistencies.
- Files presented to the PPB's management-level review process, the Review Level Committee, (and later to PARC) were missing a great deal of relevant, and sometimes critical, evidence.
- Much relevant and critical evidence was kept in detectives' "personal files," which might or might not remain in the custody and control of the PPB.
- Files did not have summaries, logs, indexing, or page numbering.
- Crucial evidence was not promptly identified and collected at the crime scene.
- Relevant forensic tests were often not performed.

Given that each of the 14 investigations considered for this report took place prior to the PARC Report during the years 2000 to 2002, it is not surprising that we found many of the same deficiencies as we did previously. We stated in the PARC Report, and repeat here, that despite the seriousness of these deficiencies in the investigations, they

can be remedied; and we have no doubt that senior management in the Police Bureau will take the necessary steps to try to correct these problems. In furtherance of that goal, Section 1010.10 has adopted new language that says (Appendix, page 15): "The Police Bureau recognizes the importance of conducting a thorough, impartial and timely investigation into in-custody deaths and the use of deadly force by its members."

Because most of the problems relating to the quality of the investigations in the 14 cases reviewed this year were fully identified and discussed in the PARC Report, it would be redundant to provide numerous similar examples in this report. We thus restrict our specific comments concerning investigations to two newly raised issues and one previously raised issue of such overriding importance that it demands discussion.

One case reviewed this year involved two reserve officers who together discharged 19 shots during an extended foot pursuit. The taped interview of one of those officers, who fired four shots, does not include any mention of his having discharged those rounds. The subject was covered in the untaped pre-interview, but appears neither on the tape nor in the transcript of the actual interview. That such a critical omission was not identified by any supervisor during the investigation process is a matter of particular concern.

Recommendation 2005.9: Supervisors in the Detective Division should review the work done by investigators to ensure that deadly force cases are appropriately investigated, and the results are properly documented.

In another case, two of the PPB members centrally involved in the incident, although neither fired his weapon, held the rank of commander and lieutenant. They were interviewed about their involvement in the incident by detectives, who in the PPB are detective sergeants. Moreover, the entire shooting investigation was conducted and led by sergeants. Good practice requires that, when a superior officer's actions could lead to discipline (as was the case here), investigations be led by, and interviews of members be conducted in the presence of, officers of equal or higher rank. A lower-

ranking officer leading an investigation creates at least the appearance of possible deference to the higher-ranking officer. And having a lower-ranking officer interview a higher-ranking officer without the presence of an investigating officer of at least equal rank not only creates that same appearance of impropriety, but also the risk that the questioning may be less probing and less objective because of the witness's higher rank. Having said this, we note that in this particular case, we found no reason to believe that either of the higher ranking officers exerted undue influence with the investigators.

The Detective Division has appropriately amended its procedures (Appendix, page 36) to provide that interviews of an involved member of command rank be conducted in the presence of a member from the investigative branch of equal or higher rank than the involved member. That provision should be further amended to make the same provisions for the interviews of witness members. Likewise, the Bureau needs to adopt a procedure that investigations be led by an officer of at least equal rank to that of the most senior officer playing a role in the incident being investigated.

Recommendation 2005.10: The PPB should adopt procedures requiring (a) that deadly force investigations be led by an officer of a rank equal to or greater than the rank of the most senior officer playing a role in an incident, and (b) that interviews of witness officers of command rank be conducted by, or in the presence of, an officer of at least equal rank to the member providing evidence.

The issue of overriding concern that we raise here, notwithstanding having addressed it in the PARC Report, is one of a strong disinclination by investigators to find that a shooting was unjustified or that the officers' performance was deficient in any way. The disinclination or bias we observed seemed to appear in rough proportion to the number of questions a reasonable investigator might have about the justification for a shooting. In general, cases where a reasonable investigator should have been more probing, detailed, and skeptical about whether a shooting was justified, within policy, or tactically sound, were more likely to have less probing investigations.

The investigators on the cases we reviewed demonstrated bias in the following ways, among others:

- Detectives did not explore the discrepancy shown by medical records that the man who was alleged to have pointed a pellet gun at officers—at which point an officer said he fired in self-defense—was shot only in the back and the back of his arm.

- Detectives did not explore why an officer did not try to use pepper spray against an unarmed man he was trying to extract from a minivan.

- In the same case, investigators did not probe the discrepancy between the officer's account that he shot the driver of a minivan to prevent being run over and the accounts of two civilian witnesses that attributed the shooting of the unarmed man to the officer's seeking to prevent his escape. Rather than probing that discrepancy, a detective tried repeatedly, but unsuccessfully, to convince the civilian witnesses to say that they perceived the officer to have been in danger.

- In a similar case, detectives questioned a civilian witness so pointedly that she modified her initial statements that suggested that an officer's shooting of another unarmed man, this time in a pickup, was unjustified.

- In the same case, investigators did not ask the officer who fired the shot why he did not wait to approach the truck, which had previously fled from him but was now caught in traffic, until two other officers who were just arriving on the scene had time to cover his approach to the pickup.

- In a number of cases, investigators asked leading questions in their interviews of involved officers and civilians that suggested reasons that the shooting was justified. For example:

Investigator: Okay, and his back is would you say his back was towards, uh, the police officers?

Civilian: Towards the police officer, yes.

Investigator: So at this point you're kind of getting a side view of him?

Civilian: Yes, that's correct.

Investigator: He moves from onto the payment, pavement and then on to a, to a dirted area and, and at that time you see him reach with his right hand, um to what area?

Civilian: Um. Like his right kind of waistband area.

Investigator: Okay. And when he reaches down there you see him pull out…

Civilian: A gun.

For another example, from another case:

Investigator: [Officer,] what kind of danger to the neighborhood would, um, a man that was armed with, uh, a handgun that, uh, you suspect may have just done a robbery and is now running from the police, what kind of danger is he to the citizens if he gets away from you?

For a final example, from a third case:

Investigator: [Officer,] at that point in time, did you have some concerns about the person who got out of the driver's seat regarding your safety, other officers' safety, or community safety?

A recurrence of biased investigations, as we have now seen from 1997 through 2001, raises the question as to whether a fair and balanced process and result can be reached without oversight by an outside agency. For just this reason, Recommendation 5.15 in the PARC Report called for civilian oversight of PPB investigations of administrative issues and analyses of tactical decisions arising out of officer-involved shootings and in-custody deaths. Our examination of the cases we reviewed this year reinforces the need for civilian oversight. See also Chapter 3, Section VI (pages 44-45) of this Report.

Finally, we note one irony arising out of the recurrent bias and/or lack of thoroughness found in officer-involved shooting investigations. While such deficiencies necessarily undermine public confidence in the PPB's ability to investigate itself, in cases where most reasonable observers would conclude that there is little doubt about the fact a shooting is justified, such deficiencies in the investigation process create doubt where otherwise none would exist.

II. Internal Review

Police agencies should conduct internal reviews of officer-involved shootings for two primary reasons: first, to hold officers accountable for actions that are inconsistent with policies, procedures, or training; and second, to use the incident as a learning tool, if appropriate, to improve the department's policies, procedures, training, and management. A meaningful review process engenders trust from the community, enhances officers' safety, and leads to less frequent and more judicious uses of deadly force.

In 2000 and 2001, the PPB used a two-tiered system of administrative review. The first level of review, also known as unit-level review, came from the involved officers' chain of command. The involved officers' unit commander was responsible for preparing a written analysis of the incident, known as an after action report, which was then forwarded to the Assistant Chief in the involved officers' chain of command for

review and comment. The second, or executive, level of review, the Review Level Committee, required an independent assessment of the incident and the analysis set forth in the after action report, by a panel comprised of (1) all the Assistant Chiefs in charge of the PPB's various branches, (2) the involved officers' unit commander, and (3) several non-voting members. The Review Level Committee discussed the incident and issued recommended findings of "justified" or "within policy" (which have always been the findings in the five years of cases we have examined) to the Chief.

The PPB has recently instituted a Use of Force Review Board (see Section 335.00 at Appendix, pages 4-6) that will review all officer-involved shootings, in-custody deaths, cases where a subject is hospitalized as a result of a use of force, and other serious incidents. The new board has replaced the Review Level Committee for such cases. PARC will analyze and discuss the policies and procedures relating to the Use of Force Review Board in a subsequent report.

We will briefly examine the use of the unit and executive levels of review in the 14 cases we examined. We repeat the caveat that the areas we identify as needing improvement arose out of processes that in the main occurred from 2000 to 2002, well before the issuance of the PARC Report in 2003.

A. After Action Reports

The after action reports showed a lack of commitment to the review process in several ways. First, after action reports were not drafted (or were lost) in six of the 14 cases we examined. (The PPB asserts the missing number is three, but PARC has never received six after action reports despite considerable follow-up with the appropriate staff member.) In a seventh case, the after action report addressed solely what happened after SERT and the Hostage Negotiation Team had been mobilized and did not examine the officer-involved shooting that preceded the activation of those two specialized units. Thus, 50 percent of the shooting incidents were not subjected to a unit-level review.

Second, the reports that were done presented a range of problems. For example:

- An after action report was authored by a lieutenant who was a key actor in the events and thus should not have been reviewing his own actions. Moreover, the lieutenant's commanding officer was also a key actor in the events that ended in an officer-involved shooting, creating a second reason the lieutenant should not have been conducting that review, since a lower-ranking officer should never review the conduct of his commanding officer.

- A different after action report did not find fault with the failure of a sergeant to supervise and to back up an officer who was left to confront a man with a gun alone.

- A third after action report did not address numerous areas for tactical improvement in the case, including officers exposing themselves to being shot by the armed passenger to whom they were paying no attention, a solo foot pursuit at night after an armed suspect, poor communication, and the failure of a sergeant on the scene to direct his subordinate to terminate the pursuit he later said he knew was too dangerous to maintain.

By contrast, the report in another case properly fulfilled the purpose of an after action report by identifying a key tactical error—an officer reaching into a car to try to grab the keys—and by setting forth better options that the officers could have pursued that might have prevented the need to use deadly force.

B. Review Level Committee

Four, or 29 percent, of the 14 cases we examined were not considered by the Review Level Committee—an improvement over the 44 percent failure to conduct such

executive-level review for cases considered by the PARC Report. Two of the ten 2000-01 cases subjected to Review Level consideration, however, were not reviewed until early 2005, when our work brought that oversight to the PPB's attention. While it is desirable that all shooting cases receive executive-level review, a delay of four and one-half years undercuts both the accountability and information-feedback reasons for internal review.

As was true in the PARC Report, all uses of deadly force considered by the Review Level Committee were unanimously found to be justified. Consistent with its procedures, the Committee made no other findings. From March 2001 to March 2002, however, the Committee engaged in an effort to track the follow-up on non-disciplinary recommendations made by the Review Level Committee.

Only one of the cases we reviewed this year generated a recommendation that was placed on the list used for tracking follow-up. The case involved one of the three shootings arising out of an attempt to extract a driver from a vehicle—the same case where the precinct commander appropriately addressed the tactical issues in his after action report. (The other two 2000-01 vehicle extraction cases were not reviewed, either at the unit or the executive level.) The Review Level Committee's recommendation in March 2001 was that the Training Division put together a training bulletin addressing the issue of officers reaching into occupied motor vehicles. No training bulletin was issued, but following other car extraction shootings in 2003 and 2004, the issue has recently been addressed in some depth in mandatory in-service training.

New Recommendations

Recommendation 2005.1: The PPB should set a firm deadline for making its early intervention system operational and should prioritize its resources so as to ensure meeting that deadline. *(See page 22.)*

Recommendation 2005.2: The PPB should promptly draft procedures to govern the administrative investigations by the Training Division concerning officer-involved shootings, in-custody deaths, and injuries resulting in hospitalization, and it should supplement its procedures for such investigations by the Internal Affairs Division so that they are at least as thorough as its procedures for misconduct investigations. *(See page 30.)*

Recommendation 2005.3: PPB policy should make clear that administrative investigations of in-custody deaths and uses of force resulting in hospitalization are mandatory by eliminating the contradictory provisions from Section 335.00 that make them discretionary. *(See page 30.)*

Recommendation 2005.4: PPB policy should prohibit involved officers from being transported by their assigned partners and should require, when feasible, that the transportation be done by a supervisor or a detective. *(See page 35.)*

Recommendation 2005.5: PPB procedures should require (a) that a supervisor and sufficient cover officers be present before members try to extract an apparently unarmed person from a vehicle, and (b) that tactics calculated to protect the safety of both the officers and the occupant of the vehicle be employed. *(See page 55.)*

Recommendation 2005.6: The PPB should develop a policy that prohibits it from responding to routine patient management situations in mental health facilities, and the Bureau should advise all mental health providers in the City of Portland of that policy. *(See page 59.)*

Recommendation 2005.7: The PPB should clarify its policies relating to medical attention and rendering aid to make clear that officers who have used deadly force are required to ensure that medical aid is rendered to injured persons as soon as possible, unless the circumstances clearly demonstrate that to do so would unreasonably endanger the officers or the medical personnel. *(See page 63.)*

Recommendation 2005.8: The PPB should promulgate the policies and procedures necessary to require in all instances of the use of deadly force where a person is seriously injured: an Internal Affairs administrative investigation, and an explicit determination by the Use of Force Review Board, as to whether there was compliance with the policies for ensuring that medical aid is appropriately and timely rendered. *(See page 63.)*

Recommendation 2005.9: Supervisors in the Detective Division should review the work done by investigators to ensure that deadly force cases are appropriately investigated, and the results are properly documented. *(See page 66.)*

Recommendation 2005.10: The PPB should adopt procedures requiring (a) that deadly force investigations be led by an officer of a rank equal to or greater than the rank of the most senior officer playing a role in an incident, and (b) that interviews of witness officers of command rank be conducted by, or in the presence of, an officer of at least equal rank to the member providing evidence. *(See page 67.)*