Anaheim Police Department:

Independent Review of Major Incident, Use of Force, and Internal Affairs Investigations

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Introduction

This report emerges during a period of continued national focus on policing and police accountability. At the state level here in California, two significant pieces of legislation from 2018 have already increased public access to sensitive information about law enforcement.[1] Meanwhile, pending legislation has advanced efforts to reduce deadly force incidents through higher thresholds for officers and an emphasis on the de-escalation of potentially violent encounters. And public activism of various kinds reflects the ongoing push for re-examined approaches to enforcement philosophies and community relations.

These developments have inevitably influenced local jurisdictions and created both challenges and opportunities. This is true in Anaheim as well. Since the time of our last report in 2018, the City has begun to adapt to its new transparency obligations. And it has welcomed both a new Chief for the Anaheim Police Department ("APD") and a new City Manager – two individuals who arrive as outsiders with an opportunity to forge new visions and directions.

The individuals are joined by a new oversight entity that has a formal potential to also influence policing in Anaheim. The new Police Review Board ("PRB"), comprised of seven volunteer residents from the City who were selected randomly after an initial qualifications screening, held its first public meeting in September of 2018. This "version" of the PRB builds on the experiences – and occasional frustrations – of the original pilot project that ran from 2014 to the beginning of 2017.

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[1] SB 1421 took effect on January 1, 2019. It removes certain confidentiality protections that had been in place for decades, and requires police agencies to produce records related to investigations and discipline in conjunction with deadly force incidents, uses of force that result in serious injury, and certain cases of serious officer misconduct. SB 748, which took effect on July 1, 2019, places new requirements and time deadlines on agencies for the public release of recorded evidence (such as body-camera video) after certain categories of critical incidents, including officer-involved shootings.

The mission and duties of the new Board are the product of extended discussion and consideration by the City government, the Police Department itself, and stakeholders from throughout Anaheim. Its members received extensive training on police operations, internal review systems, and civilian oversight prior to beginning their official three-year terms. During this period, it adopted the following mission statement:

> *Serving as the community's voice, the Police Review Board brings added oversight and accountability while also building trust between the Anaheim Police Department and those it serves. The Police Review Board brings independent review of major incidents while also serving as a forum for community feedback and education about the role of policing in Anaheim.*

It is true that, like its predecessor, it does not have investigative authority, or power to impose specific outcomes in cases on the Department. However, and by design, this Board has more structure, focus, and responsibility than ever before. It meets monthly and has the ability to engage APD with questions and concerns regarding both individual matters and broader subjects relating to policing policy. Moreover, and compared to the previous version, the Board is stronger in specific ways that include the following:

- Increased access, including real-time response to the scene of critical incidents such as officer-involved shootings
- Better structure for intake and monitoring of public concerns
- Greater latitude to pursue policing topics of interest
- Clearer obligations in reporting and public engagement.

As it approaches the end of its first year of service, the Board has learned a great deal about policing in general and APD in particular. It is also seeking and finding ways to share its collective impressions and represent the public as it moves forward in its tenure.

At the same time, OIR Group will continue in our role as professional monitors of police practices – an oversight relationship with Anaheim that dates back to 2007. We will utilize our own complete access to APD investigative materials to offer our impressions and make recommendations for reforms or enhancements of APD operations. And we will serve as a liaison to the Review Board: presenting our findings to the members and being guided by the priorities they emphasize as their tenure unfolds.

This Report is a component of that process. It covers our assessment of cases that were completed since we finalized our last report in early 2018. In doing so, we go back to address several significant matters that occurred or were resolved during the months between the end of the first Board's two-year term and the development of this new model. These cases include the following:

- 13 Major Incident Review Team ("MIRT") reports on critical incidents. These include six officer-involved shootings (including three fatalities), three traffic accidents resulting in injury in the context of APD pursuits, two in-custody deaths, a dog-shooting case, and a non-hit shooting involving an off-duty officer from another agency.
- 38 Internal Affairs investigations into allegations of officer-misconduct – a sampling of the total output of completed cases since the beginning of 2017.
- 12 supervisory reviews of uses of force as entered into the APD "Force Analysis System" ("FAS") In keeping with our past practice and agreement with the City, we look at these cases *after* the Department is done with them. This obviously means that our role is not to influence specific outcomes. Instead, it is to assess the legitimacy of the Department's processes, to point out potential areas of improvement, and to offer the public some sense of the nature of internal police review in Anaheim – in terms of both the investigative and remediation processes and the substance of the underlying incidents and allegations themselves.

As in past years, APD has been collaborative and forthcoming in providing us with the materials to do our work. This includes the complete investigation files for the various cases – including body-worn camera recordings that we can directly assess and compare to the written accounts of the same incidents.

Ideally, the access that we continue to have, and the accounting of related impressions that this report represents, will heighten the impact of the commitment to oversight that the Police Review Board represents. Additional scrutiny will inevitably reveal problematic or disappointing behaviors by the police. But it will also reduce the uncertainty and suspicion that have sometimes compounded those concerns. And it may promote a better understanding of the challenges the police face, the good work they often do, and the efficacy and thoughtfulness of their review efforts. We hope this Report will offer a useful window into APD's operations.

Major Incidents

As we have emphasized in the past, APD's "Major Incident Review" process has evolved over the years into a constructive, comprehensive, and rigorous model of self-scrutiny. Beginning in the immediate aftermath of a critical incident such as an officer-involved shooting or other in-custody death, APD goes beyond the standard (and important) criminal investigation process by also initiating an administrative response.

The process starts with prompt notification, after which designated supervisors roll out to the scene and begin acquiring information about all aspects of the case. A representative from OIR Group also receives notification and responds in person in order to get a briefing on the initial circumstances of the case and learn of any emerging issues or concerns. Starting in July of 2018, the Police Review Board members also take turns responding and have the chance to go "behind the yellow tape" in unprecedented ways. In fact, to our knowledge, it is the first volunteer Board in the nation that has been entrusted with such a responsibility. This access is a credit to the City's leadership in seeking to improve transparency, and to the Department for embracing this innovation.

From there, a few different phases occur. Within a week or two comes the first presentation to the Department's Executive Command and a range of subject matter experts from the agency. The Major Incident Review Team (MIRT) of investigators offers a detailed overview of known facts – and nowadays is able to do this with significant direct evidence in the form of recordings of 911 calls and officer radio traffic, and the body-worn camera footage acquired from involved personnel.

Because the criminal investigation is still in its early stages at this point, and because evidence (including officer statements and forensic/medical results) is still being gathered, the emphasis here is less on individual officer performance and accountability than on issue-spotting in terms of concerns that may affect the

Department more broadly and merit more prompt attention/remediation. These could include assessments of policy or identification of training needs, as well as interactions with other entities (including the District Attorney's Office) or the community.

Importantly, *all* aspects of the case – from the initial circumstances of the call to the on-scene aftermath – are included and discussed as potential areas for intervention in this first presentation. This commitment to "holistic" review is one of the hallmarks of the MIRT process and certainly among its greatest strengths. And there are often "action items" that emerge for appropriate follow-up in the coming weeks and months.

From there, the MIRT investigation continues in the background – even as it defers to any pending criminal review with regard to officer performance and accountability issues. Once the District Attorney's Office has completed its review and made a determination about whether involved personnel have legal culpability under the Penal Code, the focus shifts to an internal, administrative determination as to whether the involved officers' actions complied with Department policy and whether any consequences are warranted – from training to discipline to possible separation from employment. The completed investigation is reviewed by the Department's leadership, and final outcomes are reached.

In our experience, the MIRT process has often produced thoughtful analysis and productive reforms – even in cases where we might question a specific outcome or wish the scrutiny had been more wide-ranging. That is true in the 13 examples we discuss below, and forms the basis for our critique of the decision *not* to convene a MIRT for one major incident we also address at the end of this section.

Even so, any thorough and complex endeavor – especially one that deals with sensitive information and relies on input and feedback from multiple participants – will inevitably experience inefficiencies and differences of opinion, or fall short of its peak potential. For that reason, we have always cited the shortcomings that we have noticed along the way, and made attendant recommendations. Those are included below as well.

Among the 13 incidents we reviewed for this report, there were several recurring themes or problems we identified, many of which have been raised as recommendations in prior reports as well.

Delay in Formal Completion

While the APD conducts its initial MIRT meetings within a short time after an incident, many of the cases we reviewed were not officially closed for many months.[2] One case was not closed until over two years after the date of the incident. Even though most action items identified in the initial MIRT meeting are completed within a few weeks, the inordinate and unexplainable delay in formally closing cases with the approval of Department executives undermines the impact of the reviews.

> RECOMMENDATION 1: APD should develop and enforce internal guidelines and expectations for when an administrative review of a major incident is to be formally completed.

Administrative Interviews of Involved Officers

As in earlier cases on which we have reported, APD continues to rely entirely on the interview conducted by the District Attorney in probing the mindset and decision-making of the involved officers. Because the District Attorney's interview does not focus on tactical decision-making or other aspects of the event that are important to the Department, there is a potential for gaps regarding these significant matters. Similarly, supervisors who may have influenced events but were not direct shooters or witnesses are also not always interviewed at this stage.[3] As a result, as detailed in a number of incidents discussed below, the Department's MIRT reviewers cannot fully explore all of the key facts necessary to their deliberations.

As we have said in past reports, the span of relevant performance issues extends beyond the important but narrow parameters of legal justification that are the focus of the criminal review. Accordingly, we advocate a standard practice of interviewing involved officer separately and with an administrative focus.

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[2] The fact that a number of cases in this review period were all closed on the same day, coinciding with a personnel shift, suggests that some of the delays were the result of administrative oversight that the Department remedied once identified.

[3] The Department reminds us – appropriately – that its administrative investigators do in fact monitor these District Attorney interviews, and have the chance to submit questions to the process if they desire. While this is useful as an option, and presumably productive in practice, we maintain that it is not a substitute for a more complete and administratively focused discussion with involved personnel.

> RECOMMENDATION 2: The Department should standardize the practice of conducting separate administrative interviews of involved officers, witness officers, and on-scene supervisors in a shooting, to ensure that all potential performance and policy issues are properly addressed.

We also have written extensively in prior reports about the timing of involved officer interviews, both relative to the incident and to the officer's ability to view his or her body-worn camera or other video or the incident. These issues continue to come up in the cases we review.

The delays that we continue to see before officers provide voluntary statements – as long as two and nearly three weeks – have deleterious effects on investigative soundness and are not consistent with best investigative practices.[4] Proponents of the delay have relied on claims that memory and recall improve over time, after an officer has gone through a couple of rest cycles. However, scientific evidence generally supports the contrary position that memory degrades over time.[5]

> RECOMMENDATION 3: The Department should prioritize the obtaining of an interview statement before the end of the relevant shift from officers who are involved in a shooting; if they are unwilling to provide a voluntary interview, they should be ordered to submit to an administrative one.

As for the body camera recordings, we believe that a chance to review them – and supplement their initial testimony as needed – is best done after an initial rendering of events that is unaffected (even subconsciously) by the introduction of a different perspective.

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[4] To the Department's partial credit, it has recently imposed a new 7-day limit on the timing of these interviews, thus limiting its deference to the criminal investigation and eliminating the more extreme delays we have noted at times. While this is a step in the proper direction, it nonetheless does not resolve the main concerns that militate in favor of "same shift" interviews.

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

RECOMMENDATION 4: The Department should implement an investigative protocol that restricts the viewing of body-worn camera recordings by officer involved in a critical incident until after they have given an initial statement about their actions and perceptions.

Identification of Tactical Issues

We cite numerous examples in our individual case discussions of questionable tactical decisions that were not fully identified, discussed, or explored in the MIRT process. In general, we found that APD is oriented towards readily identifying and addressing systemic and equipment issues, but tends to refrain from questioning involved officers about tactics and to identifying tactical decision-making that may have been less than ideal.

RECOMMENDATION 5: APD should strive to achieve with more consistency the identification and remediation of tactical decision-making issues that the MIRT process accomplishes at its best.

Shooting Case # 1

This fatal officer-involved shooting incident occurred in the middle of a residential street. It ended an encounter with a male subject who had been involved in gun violence at two locations that day – including the one where the confrontation with police occurred. Three APD officers fired a total of 12 rounds in response to the man's sudden movement in the direction of a gun he had placed in the street moments earlier. That lunging movement also brought him closer to a shooting victim of his, who was lying in the street with a leg wound. The second man survived his injury; the subject was pronounced dead at the scene.

This incident began in a nearby location, where the subject's brandishing of a gun while inside his own car and firing of several shots (including into his own apartment) prompted calls to 911. As APD officers responded to the first scene, the subject continued toward the home where his estranged wife was staying with their children. It was there that he encountered another relative – the man whom he shot in the leg. His wife happened to arrive home in her car at that point; when

her husband began running toward her with the gun in his hand, she drove away and called 911 herself.

The subject then stood over the fallen man and smoked what was later determined to be methamphetamine as he screamed further threats. At this point multiple officers – including a helicopter unit that circled above the final phase of the encounter – arrived and began to make a coordinated approach in the direction of the subject and the victim. While the subject did respond initially to the officer commands that he drop his gun, he did not comply with their orders to get on the ground, and instead continued to sway and move from side to side erratically.

The officers continued to close distance, feeling obligated to take action rather than waiting because of the subject's continued proximity to both the weapon and the shooting victim. One officer fired a less-lethal round that struck the subject in the chest but was otherwise ineffective. Soon after that, the subject made the abrupt movement that precipitated the shooting itself.

After conducting its criminal investigation into the incident – which included access to multiple body-worn camera recordings, a witness cell phone video, and accounts from the shooting officers,[6] witness officers, and bystanders – the District Attorney's Office issued the letter of opinion 15 months after the event. Its review of the case determined that the officers had been justified under the totality of the circumstances in their use of deadly force. These circumstances included the man's dangerous and threatening behavior prior to the officer's arrival, the need to intervene on behalf of the shooting victim, the subject's erratic actions and refusal to comply with commands, and ultimately his movement in the direction of the weapon.

MIRT Review and Analysis

The Department found the officers' actions to be within policy, and in fact authorized commendations for the three shooting officers and several other involved personnel. This was, in fact, one of five "action items" to emerge from the initial MIRT presentation.

[6] Two of the officers' voluntary interviews occurred 12 days after the incident, and the other happened 18 days later. These serious delays in obtaining statements from the involved officers do not comport with best investigative practices. The officers also reviewed body camera recordings prior to giving their statements.

As for the other action items, they show the range of issues that the review can potentially identify and address. One item related to the incorporation of tactical lessons from this and other recent critical incidents into responsive training for all Department-members. Others related to equipment, including the need for training on rifle racks within patrol cars and facilitating weapon security and removal. The Air Support Unit, which had responded to the scene, was assigned to develop new protocols for recording incidents to which it responds to ensure standardized evidence gathering. And the crime scene investigation protocols also received attention, in the form of the acquisition of new portable lighting equipment and screens to assist the Forensic Unit and help maintain scene privacy.

These were effective interventions by the Department that we endorse. At the same time, we point out some areas where more attention may have been worthwhile:

- The involved officers did not have a separate administrative interview; instead, the MIRT review relied on statements from the criminal investigation in shaping its decisions about compliance with Department policies.
- The MIRT presentation prompted concerns about the helicopter pilot's decision to go home at the end of his shift rather than make himself available for the questioning that night. However, no documentation of any subsequent remediation in this regard was in the case file.[7]
- The MIRT presentation also prompted discussion of whether officers utilized cover effectively, and why an officer was driving to the scene with a rifle out of its vehicle rack. Neither of these issues received formal attention in the MIRT memorandum.
- The MIRT presentation included depictions of bullet strikes to a home in the residential neighborhood where the shooting took place. Issues of backdrop and crowd control were seemingly germane to the incident without receiving review or response.

[7] The Department asserts that such a step did indeed occur informally. This is good to hear from a substantive perspective; however when such interventions occur after arising from the MIRT process, they should be documented in the MIRT file.

RECOMMENDATION 6: The Department should make the assessment of bullet strikes – and their implications for backdrop and other tactical considerations – a routine part of its shooting review process.

Shooting Case # 2

On the date of the incident, Officer 1 was working traffic enforcement and initiated a traffic stop of an SUV that was travelling in excess of the posted speed limit. Officer 1 parked his motorcycle behind the SUV, which was occupied by a married couple with their two toddlers in the back seat of the vehicle. As Officer 1 was writing a traffic citation, a truck pulled up and stopped close to the police motorcycle.[8]

The driver of the truck got out of his vehicle and started yelling at the officer when he was approximately 15 feet away. As documented in the officer's digitally-activated recorder, the man yelled "mother f***er" and "f*** cops" at the officer. The subject then brandished a knife. He returned to his truck briefly and then ran with the knife toward Officer 1.

Officer 1 drew his firearm and pointed it at the subject, commanding him several times to drop the knife. The subject continued to run towards Officer 1 who then backpedaled away from him. Officer 1 said that as the subject continued to close the distance between them to approximately six to eight feet, he fired six rounds at him, stopping his advance.

After being shot, the subject slowed but then moved past Officer 1 and toward Officer 2, who was coincidentally nearby, had observed the encounter, and driven to the location to assist her fellow officer. Officer 2 said as she drove to the location she focused her attention on Officer 1 because he was backpedaling toward her advancing vehicle. Officer 2 said that she was afraid she was going to hit Officer 1 with her vehicle and had to firmly apply the brakes to avoid doing so, causing her brakes to lock. As a result, Officer 2 said she lost sight of the subject.

When Officer 2 then attempted to get out of her vehicle, she was surprised to find the subject at the front driver's side door of the police car, holding the knife and

[8] At the time of the incident, motorcycle officers were not equipped with body-worn cameras. That has since been changed.

making a jabbing motion at her. Officer 2 stated that she then recognized that she had few options since she could not close the door or drive away. To create some distance, the officer leaned back into the passenger seat of the police car and fired two rounds through the open door.[9]

The subject went down, and while the involved officers took him into custody, a third officer responded on scene with a first aid kit and rendered medical aid until paramedics arrived. The subject was rushed to the hospital, where he expired.

Crime scene technicians found that the SUV had sustained several bullet strikes on the driver's side door panel, rear bumper, rear tailgate, and near the driver's side running board.

The decedent's close family member reported to investigators that the subject had a prior history of mental illness.

The Orange County District Attorney found the use of deadly force by the involved officers to be justified.[10]

MIRT Review and Analysis

The MIRT review found the use of deadly force by the involved officers to be within Department policy. To its credit, it also identified the following issues:

- *Field contact not communicated.* The review found that Officer 1 had not notified dispatch of his traffic stop. And by the time that the officer found himself in peril from the man armed with a knife, he said that he did not have time to radio for assistance. The MIRT attendees recognized the importance of officers notifying dispatch whenever they are involved in enforcement action so that their location is known and assistance can be timely provided when necessary. To reinforce this expectation, APD produced a law enforcement bulletin advising its officers of the need to communicate all field contacts to dispatch.

[9] While Officer 2 was equipped with a body camera on the day of the incident, she did not activate it until after the shooting. Since this incident, and to its credit, APD has strengthened its body camera activation policy and training to better ensure activation and the ensuing capture of critical incidents.

[10] This finding relied in part on the voluntary statements of the involved officers. No statement was obtained from the involved officers until two days after the incident.

- *Automatic Vehicle Locator not functioning.* The review also found that the police motorcycle's Automatic Vehicle Locator (AVL) was not functioning properly. In response, the AVL was replaced so that the communications center could use the device to obtain the location of the motorcycle if necessary.

- *Firearms Training: Unconventional Shooting.* The review noted that the great majority of firearms training for APD officers presupposes that they will be able to fire their weapons from conventional standing positions. This incident provided an example of an occasion where the officer in her car did not have the opportunity to position herself in a traditional firing stance. APD determined that it was important to advise and train officers on this potentiality. Accordingly, the Department developed in-service training and a law enforcement bulletin to better prepare officers for the eventuality of needing to use deadly force from unconventional positions.

- *Dealing with persons in mental health crisis.* The MIRT review found that the incident illustrated the need for additional training to officers on dealing with mentally ill individuals. Accordingly, the Department increased time spent on in-service training for responding to those in mental health crisis, including making available to its officers five videos created by the Mental Health Association of Orange County.

However, there were a number of tactical issues that the MIRT process did not identify:

- *Officer 1's backdrop.* After the subject aggressed Officer 1, he backpedaled and ended up firing numerous rounds at the subject. The officer's positioning caused a significant percentage of his rounds to strike the SUV he had pulled over. Fortunately, none of the bullets entered the cab of the vehicle or struck its occupants – a couple and two toddlers – who had been pulled over for speeding. Those consequences could have been catastrophic.

  Officers are trained to consider their backdrop when deciding whether and how to use deadly force. Yet in this review, because APD did not conduct an administrative interview, Officer 1 was not questioned about this aspect of his decision-making, whether he even recognized that the SUV was in his line of fire, or any alternatives he considered.

- *Officer 2's approach to scene.* The way in which Officer 2 responded to the scene placed her at a tactical disadvantage. First, she apparently drove too close to Officer 1 and admittedly locked her brakes while trying to avoid striking him, thereby endangering him further as he was trying to address the threat posed by the subject. Also, as she focused on this driving error, the officer lost sight of the assailant and found herself at a tactical disadvantage when he suddenly reappeared at the side of her vehicle. The officer essentially became trapped inside her own police car, thus limiting her tactical options. However, the MIRT did not formally evaluate these decisions, and therefore lost out on the potential learning opportunities they presented.

- *The "21-foot rule": Failure to address articulated misconception.* During his interview, Officer 1 mentioned that he was concerned about the man armed with a knife because of his awareness of the "21-foot rule." That "rule" instructs that an armed attacker can clear 21 feet in the time it takes most officers to draw, aim, and fire their weapons. It has become largely discredited because many officers came to view it as legal justification for shooting a person with a knife anytime he or she is within 21 feet. APD's Training Division does not teach this principle as a rule because of the recognition that every potential threat is situational. Instead, the preferred way of addressing this concept through training is precautionary – understanding that a subject with an edged weapon can attack more quickly than one might expect, officers should think defensively when confronting a knife-wielding subject and seek distance and cover to buy time and create additional options for dealing with the threat.[11]

  In spite of training emphasizing these defensive concepts, many officers – including the one involved in this case – continue to think of the "21-foot rule" as an established principle that offers justification for the use of deadly force. APD should use this incident as indication its actual position on this concept needs to be expressed and reinforced more overtly.

[11] Recently, the Police Educational Research Forum, a national progressive think tank for police executives, has written about the shortcomings of the 21-foot rule and recommended replacing it with an emphasis on principles of time, cover, and distance.

RECOMMENDATION 7: APD should brief the involved officer about the shortcomings of the so-called "21-foot rule" and issue a training bulletin instructing its officers on the principles to be applied when confronting a subject armed with a knife.

Shooting Case # 3

This was a fatal incident in which an officer shot and killed the subject as he paced in the driveway/courtyard area in front of a single-family home. The man had been involved in a couple of collisions on a nearby freeway, had abandoned his damaged vehicle on an off-ramp (as had another person who was in the car with him), and had travelled on foot to this location. There, a total of three patrol officers confronted him as an APD helicopter flew overhead. Within two minutes of the officers' arrival, one of them fired three times. The subject fell to the ground and, in spite of medical aid provided at the scene by officers and paramedics, died at the hospital from his wounds.

The police became involved in this matter as the result of 911 calls from drivers on the freeway where the hit and run collisions occurred. One of the motorists who had observed the collisions happened to be an off-duty officer from another agency; he trailed the two subjects as they fled from their car and spoke with dispatch personnel about his observations.

Three officers and the Department helicopter quickly arrived at the scene, where the subject had been behaving erratically according to witness accounts: taking off his shirt, pounding his chest, and cursing at people. He eventually ended up outside a home, across the street from a restaurant parking lot where the off-duty officer was watching him, and where others were present as well. He apparently knew the residents there, but they were reluctant to let him inside or deal with him because of his agitated condition.

Before they had time to formulate a detailed tactical plan, the subject emerged into the courtyard area outside the house and confronted the officers, who were now spread out on the other side of a fence that provided limited cover and concealment. The officers noted immediately that the subject had his right hand behind his back and his left hand in his pants pocket. They gave commands for him to show his hands, but he not only refused to comply but swore at them and yelled repeatedly for them to "shoot."

At this point, the officers struggled from their different vantage points to ascertain what the subject was holding behind his back—though he seemingly intended for them to think it was a weapon. After inconclusive communications among themselves, one officer became convinced that the subject was armed. This was enhanced by communication from the helicopter observer, who stated that he thought it was a gun. Meanwhile, the other officers offered different interpretations, with one saying he had seen a "wallet" and the other a "cell phone."

Less than two minutes passed between the officers' arrival and the shooting. During much of that time, the subject defied repeated instructions from the officers and kept his hands out of sight. The first officer ultimately gave one additional "Let me see your hands!" command; within four seconds, he observed a "jerking" motion that he perceived to be a precursor to the subject's firing at the officer closest to him and/or the people across the street. In response to this perceived threat, he fired the three shots that wounded the subject and ultimately proved to be fatal in spite of subsequent medical aid.

Neither of the other two officers fired. A search determined that it was, in fact, a cell phone he had been holding.

The District Attorney's investigation was able to draw upon video evidence from the helicopter as well as from the shooting officer's body-worn camera. (The other two officers had turned off their cameras at an earlier point in the shift and then failed to re-engage them before the shooting.) Investigators also interviewed the two witness officers before they went home that day; the shooting officer provided a voluntary interview three days later.[12]

The District Attorney opinion, which came out seven months after the incident, asserted that the evidence did not lend itself to prosecution: there was not a sufficient basis to establish that the officer had acted unreasonably, and several factors that would allow a jury to conclude instead that the deadly force was reasonable and justified. Apart from the subject's own erratic behavior, lack of cooperation, and aggressive gestures that seemed intended to provoke the

[12] Moreover, contrary to best investigative practices, the involved officer was provided an opportunity to review his body worn camera footage prior to being interviewed.

officers,[13] the key issue was the nature of the concealed object that the subject was holding – and how the officers' apparently divergent interpretations factored into the reasonability of the shooting.

To its credit, the D.A. letter addressed the issue candidly, and acknowledged the most concerning evidence from the various recordings. This included a sequence in which the officer who ultimately fired asked what was in the subject's hands. Officer 2 answered "Cell phone" on two occasions in quick succession, bracketing Officer 3 saying "Wallet." The shooting officer then said, "Don't say that," in a low voice, and went back to expressing his concerns over the radio to the helicopter crew. The shooting ensued shortly thereafter.

The conflicting observations raised significant questions. So too did the shooting's officer's odd, "Don't say that" instruction, which arguably implied a desire to manipulate the threat assessment toward a deadly intervention.

Asked about this moment, the officer explained his reasons for discounting his partners' assessments – though they proved to be more accurate than his own. He was the by far the most experienced of the three, believed his partners to be uncertain, and was focused on both the subject's aggressions and the danger he potentially posed to both the police and others in the area. As for the other two officers, both pointed out that they had indeed lacked certainty about what they had seen. They also cited the fact that the situation evolved beyond their initial glimpses of the subject's hands, and that they were concerned enough to unholster their own weapons and point them at the subject (though, to reiterate, they did not fire).

MIRT Review and Analysis

In terms of the initial MIRT presentation, the only formal action item (apart from recognizing the need for administrative interviews of involved personnel) related to updating the helicopter recording equipment. This was in reaction to the concern that the quality of the recordings did not correspond well to the live feed that involved personnel could hear during the incident.

The Department also recognized the potential influence of another equipment issue: the battery life of the body-worn camera model that officers were then

[13] The autopsy established that the subject, who had several prior contacts with law enforcement, was under the influence of methamphetamine at the time of the incident.

utilizing. The cameras were replaced several weeks after the incident, thus eliminating this common problem; in the meantime, the Department issued a prompt training bulletin with tips on preserving battery and ensuring that the cameras would be ready when needed. In this case, unlike most cases reviewed in this report, the Department did conduct separate administrative interviews of the involved officers, and delved into two prominent issues. One was the fact that both non-shooting officers had not recorded the key moments on their body worn cameras. The other was the issue of the discrepancy in reactions regarding what the subject was holding in his hands, as well as the shooting officer's intentions in seemingly rebuking his partner's observation.

The body camera question was relatively straightforward. Both officers had turned off their cameras at an earlier point in the shift, in what was apparently a common strategy for dealing with the limited battery life of the equipment. Once the need to re-engage arose – and under stressful conditions – both had experienced "user error" in accomplishing this until after the shooting had occurred.

In the short run, the Department responded to this issue by sending out a training bulletin on preservation of batteries and the importance of adhering to policy. More substantively, and within weeks of the incident itself, the agency shifted over to updated camera technologies that mitigated the underlying problem.

As for the clash in observations, the MIRT interview with the shooting officer probed this question at some length. During the video-recorded interview, the officer acknowledged the troubling impression that his statement created. He explained that various factors and observations had already furthered his own belief that the subject was armed. Accordingly, in his mind, his partners' statements were both incorrect and – because uncertain – potentially dangerous. Relying on his own interpretation of the subject's actions – as well as the input from the helicopter observer who thought it was a weapon – he gave further warnings to the subject and said he fired when he detected an aggressive motion.

The respective interviews of the other two officers provided additional details. The officer who said "cell phone" twice told the MIRT investigators that he had not been certain in the moment, and the other witness officer expressed his own concerns that the subject had been armed. (In fact, he did not even recall saying "wallet.") Moreover, considerable movement by the subject – including the purposeful concealing of his hands – had occurred after those verbal exchanges

between officers and before the shooting. And the officer at whom the "Don't say that" comment was directed did not even recall hearing it when asked.

Taken at face value, these statements have plausibility. (For example, "Don't say that," had been uttered in a low tone of voice, and the ambient helicopter noise and focus on the subject make it credible for the other officer to have missed it.) Still, given the possible implications and the objectively troubling nature of the recorded comments, it would seemingly have been worthwhile to pursue those specific interactions with all available rigor. Most obviously, the investigators never attempted during the administrative interviews to refresh the witness officers' recollection by playing the recordings for them. While we have long espoused a preference for obtaining "clean" statements *prior* to letting involved personnel view video, there is certainly value to *subsequent* sharing of it in an effort to supplement the testimony and address possible gaps in the evidence.

The point is not to play "gotcha" in an assumption that the officers have been caught in an intentional lie. We recognize that discrepancies can have many explanations, many of which are benign and common to the experience of recollecting a high stress event. Nor do we discount the value of the detailed probing of this question that did occur. Still, it seemed to us that the obvious significance of the gap warranted pushing a bit harder in the form of the recordings themselves.

Ultimately, the Department determined that the use of deadly force was in policy, and that no other policy violations had occurred.

As for the failure by both witness officers to have turned their cameras on before the shooting, this was addressed and attributed plausibly (if with the aid of some leading questions by the interviewers) to the equipment deficiencies cited above. In combination with both officers' relative lack of experience and the stress of the situation, the lapse was understandable, and the Department deserves credit for the relevant bulletin it produced within days of the incident.

Still, the lack of video from the two officers was a problem – and the third officer had managed to surmount the technical difficulties cited in the investigation. Though formal discipline was not necessarily warranted, addressing the issue more directly (rather than not acknowledging it in the official documentation) would have been a preferable approach.

RECOMMENDATION 8: The Department's administrative interviews after critical incidents should address key factual issues as thoroughly as possible, including any gaps or discrepancies between recorded evidence and officer recollection.

RECOMMENDATION 9: Administrative investigations should pursue all relevant policy issues (such as the body camera concerns) in connection with a critical incident and should reach documented conclusions, even if extenuating circumstances make responsive discipline less necessary or appropriate.

Shooting Case # 4

This non-fatal hit shooting incident began when a man entered a sandwich shop. He jumped the counter, grabbed a knife from the shop and began an extended interaction with the two female employees in the shop, at times threatening to kill them and at other times communicating irrational thoughts. During the encounter, one of the employees was able to call the police but could not provide a detailed reason for the call for fear that the man would discover what she was doing.

As a result of the call, an APD officer was dispatched with little information about the nature of the call. From outside the shop, he observed a man holding a knife with two female employees standing next to him. The officer called for backup, and numerous APD personnel responded. Officers formed an entry team, while others were positioned around the perimeter of the shop armed with rifles. An APD lieutenant was on scene as the incident commander.

The initial responding officer used his police car loudspeaker to issue commands to the subject to drop the knife and come outside. Instead, the subject struggled with the female employees, still armed with the knife. Officers heard the females screaming as they struggled with the subject, and the lieutenant directed the team to enter the shop.

An APD sergeant was the first officer to enter. He observed the situation and fired his AR-15 rifle at the subject, whom he said was only three to five feet from him. According to the sergeant, the man did not immediately react so he fired a second shot, and the subject went down. The female employees were removed from the

shop as officers handcuffed the subject and provided first aid. The subject was transported to the hospital and treated for gunshot wounds to his face and his wrist, and a graze wound to his head. He survived his injuries.

The Orange County District Attorney found the use of deadly force by the involved officer to be justified.

MIRT Review and Analysis

The MIRT reviewers concluded the use of deadly force was within Department policy, while identifying the following action items:

- *Tactics Training Reinforcement:* Reviewers found that at least one officer outfitted with a rifle had difficulty fitting the rifle sling. Proper use of the sling is important so that the rifle can be secured should the officer need to go "hands on" with an individual. MIRT recommended that the training staff discuss how to properly fit a patrol rifle sling, as well as the proper use of the entry team.

- *Integration of mental health professionals into the Tactical Negotiations Unit.* During the MIRT presentation, the APD's Tactical Negotiations Unit ("TNU") proposed the inclusion of a mental health professional to assist the team during training and actual negotiation incidents. Specifically, the Unit proposed to use a contract psychologist to serve as team advisor, participate in quarterly training, respond to team call outs to focus on behavioral assessments, and assist in team debriefings after a critical incident.

  While APD's intent to incorporate a mental health professional into the specialized responsibilities of the Tactical Negotiations Unit was laudable and while the psychologist attended a couple of training days, the mental health professional's integration was discontinued due to the perceived limited benefit from his continued involvement. Currently, TNU is considering having APD's licensed clinicians assist with call outs and behavioral assessments. We were advised that during a recent incident, one of those clinicians provided TNU personnel with recommendations that proved beneficial. TNU also attends quarterly California Association Hostage Negotiators training and regularly discuss major debriefs, which include presentation from psychologists.

- *Additional Mental Health Training.* California's Commission on Peace Officers' Standards and Training ("POST") training requirements do not mandate ongoing mental health training for in-service personnel. MIRT noted in this case that new officers will continue to have training DVDs on dealing with the mentally ill available for viewing. Additionally, the MIRT summary reported that on a semi-annual basis, Embassy Consulting Service will present the four-hour POST course "Interacting Effectively with the Mentally Ill" for officers who have not attended this course before. Finally, the MIRT summary reported that the Training Detail was collaborating with a skilled nursing company to attempt to develop a course addressing dementia in the elderly. It is unclear what became of this final effort.

While initiatives initially set out as action items in the MIRT process should always be subject to re-evaluation once implemented, APD has no process to ensure whether the action items are actually implemented, sustained, or appropriately modified. For that reason, we reiterate our earlier recommendation that the MIRT review reconvene after the District Attorney's opinion letter and investigative report is received to evaluate the implementation and efficacy of the action items and to address any additional issues raised by the investigative report.

> RECOMMENDATION 10: APD should reconvene its MIRT review upon receipt of the District Attorney's investigative report to identify any additional issues and re-evaluate any reforms coming out of its initial review.

This case presents a clear example of how the quality of administrative review can be diminished by the Department's failure to conduct administrative interviews of involved officers and supervisors. The involved sergeant reported to District Attorney investigators that he thought his lieutenant might have seen the subject stabbing one of the women (he had not). The sergeant said that he was afraid because he believed the subject was killing the hostages (he was not). The sergeant said that when he opened to door, he described the scene as "complete chaos," yet he was not asked to elaborate on what he meant by that statement. Nor was the sergeant asked to provide with any specificity a response to any of the following potential questions:

- What was the subject doing, if anything, to the employees when you entered?

- Was the subject simply close to you and the employees and holding a knife and that was the basis for your use of deadly force?
- Did your actual observations cause you to realize that the subject was *not* stabbing or killing the employees when you entered?
- At any time, did you see the subject make a stabbing motion with the knife to you or the employees?
- Did you see the subject make any kind of aggressive move toward you or the employees after you entered the shop?
- Did you think to provide warnings to the subject before you fired?
- Did you interpret the "lowering" you described the subject doing after the first shot as an aggressive maneuver? Was there time at that point to try to use warnings to get him to drop the knife, or to move the hostages away from him?
- Did anything else happen, with regard to the positioning or movement of the man, the employees or yourself between the first and second shot?
- Why did you believe the man presented an imminent threat to the officers entering behind you?
- Did the officers behind you fan out and triangulate as you had ordered them to do upon entry?

Similarly, the on-scene lieutenant was responsible for numerous decisions, including the makeup of the entry team, the deployment of other APD personnel, and the decision on when to enter the location. However, neither APD nor the District Attorney investigators interviewed him. Instead, the only account of the lieutenant's observations and decision-making is contained in a written report that does not fully address the sorts of questions that could have been explored in a full interview:

- How successful was the evacuation of nearby businesses?
- You indicated in your report that it was difficult to see in the shop from the position you took because of the glare of the sun. Did you think to reposition yourself to get a better vantage?
- You indicated that you hesitated in giving orders to make entry because the K9 was positioned close to you and was continually barking? In retrospect, would you have positioned the K9 to another location so he would not have been such a distraction to your responsibilities?

- A number of officers deployed on the perimeter made entry into the shop that had not been designated as part of the entry team. As a result, the shop appeared to have too many officers inside. Do you agree? In retrospect, do you think it would have been helpful to better define who was to enter and *who was not* to enter barring further instruction?

In addition, there were a number of tactical and other issues not identified or addressed during the MIRT review:

- *The use of deadly force.* APD found that the use of force comported with its deadly force policy, but issues relevant to that determination were not addressed in the analysis. For example, there was no significant inquiry into the precise actions made by the subject that prompted the officer's use of deadly force. As significantly, there was no inquiry into the sergeant's description of the subject as "ducking" between the first and second shot, as opposed to any act of aggression toward him or the female employees. As a result, there was no analysis regarding the basis for firing the second shot.

- *Distraction by K9.* As the lieutenant indicated in his report, the incessant barking by the K9 deployed near him caused him to "hesitate" in ordering the entry team into the shop. Clearly, by his own admission, the distraction by the police dog presented a tactical challenge to the lieutenant. Yet this issue was not further explored in an interview with the lieutenant nor identified as an issue by the MIRT review. This was a missed opportunity to learn from this event and find better ways to approach such circumstances in the future.

- *Entry by officers not assigned to entry team.* After the shooting commenced, numerous officers moved from their perimeter assignments and either entered or attempted to enter the commercial business. As a result, the small shop became saturated with officers with no clearly defined roles. While this fact was apparent from the video footage of the incident, the officers who moved from the perimeter to enter the business were not asked about their decisions to enter. Nor was the incident commander interviewed about the fact that non-designated officers flooded the shop. As a result, the review process was unable to effectively address the issue of assignment discipline among officers, or how to best avoid this problem in the future.

- *Lack of ballistic shield on scene.* The ballistic shield provides effective protection to an officer confronting an individual armed with a knife, and an increasing number of police agencies are outfitting their supervisors with ballistic shields to deal with these circumstances. In this case, one of the responding officers actually asked whether there was a ballistic shield on scene and was informed that there was not. However, the potential benefit of having a shield on scene and APD's shortcoming in this regard was not considered by the MIRT review team.

- *Inconsistent deployment of ballistic helmets.* A review of the body camera footage found that while some officers deployed ballistic helmets, most did not. The use of the ballistic helmet in this case could have offered additional protection to officers assigned to respond into the shop, yet this issue was neither identified nor discussed during the MIRT review.

- *Failure to activate body-worn cameras.* As noted above, not all APD officers activated their body-worn cameras prior to the shooting incident. Yet in this case, there was ample time for the sergeant entry team leader and/or the incident commander to instruct all on-scene officers to activate their body cameras. The issue was not addressed during the MIRT review.

- *Inappropriate remarks by perimeter officers.* A review of body-worn camera footage captured officers assigned to the perimeter making inappropriate statements prior to the shooting as they trained their rifles at the front of the building:

    - "F***ing head shot, f***ing problem's over."
    - "If he gets far enough away from her, knock him blind, dude."

  The comments have no place in a disciplined professional officer response. However, there was no effort by APD to either identify or address the officers responsible for making the comments. Nor were the comments presented during the MIRT review. Even at this late date, it would be appropriate for APD to now do so.

  RECOMMENDATION 11: APD's review should identify and address body-worn camera footage that reveals inappropriate and/or unprofessional remarks made by its officers.

Investigative Issue – Accuracy of D.A. Reports

Pursuant to Orange County protocols, the investigative report is prepared by investigators from the District Attorney's Office. The report becomes the basis for a report prepared by the District Attorney opining on whether the use of deadly force was justified. We found significant inaccuracies in our review of those reports.

In the investigative summary, District Attorney investigators wrote that the involved sergeant saw the man's arms around the upper body of one of the female employees with the knife in his right hand by her throat. However, in the officer's interview, there is no such recorded observation. The District Attorney letter also attributes to the involved officer a claim that when he saw the man's arm moving, he fired a second shot. But the transcript does not include this observation; instead the involved officer describes the man as lowering himself almost as if he were ducking, a significantly different account.

When APD notes that the District Attorney reports contain inaccuracies, it is incumbent that they be brought to the District Attorney's attention.

> RECOMMENDATION 12: When APD finds inaccurate information in the District Attorney's investigative materials, it should advise the District Attorney's Office so that any inaccuracies can be corrected.

Shooting Case # 5

Two patrol officers assigned to a Community Policing Team were conducting directed enforcement from a two-person patrol car in an area known for high drug activity. They had information that an identified gang member was "taxing" local drug dealers in the area, which also was frequented by homeless individuals. The officers attempted to talk to an individual in an alley who they suspected to be associated with this gang. He immediately ran, and the driver of the patrol car chased him on foot, while the passenger officer ran around the car, got in and drove in an attempt to cut off the subject's escape route. The officers quickly lost sight of each other. The officer on foot did not broadcast that he was in pursuit, and did not update his partner on his location.

The pursuing officer maintained visual contact with the subject as he ran across a major six-lane street and into a large empty parking lot behind a church. The officer deployed his Taser, but it apparently did not make sufficient contact with the fleeing subject to have any effect. The subject ran toward a concrete wall bordering the parking lot and was beginning to climb over it when a block on top of the wall came off in the subject's hands. He turned and then threw it toward the officer. The officer took a step backward to avoid the block and then fired two rounds at the subject. Both missed, and the subject continued over the wall.

The officer attempted to broadcast, "shots fired," but that communication did not transmit. The officer made no further attempts to communicate – providing neither his own location nor the subject's whereabouts – for the next 40 seconds, until the officer who was now driving the patrol car reported to dispatch, "I can't find my partner." The shooting officer then gave his location and the subject's direction of travel while officers began to establish a containment and search for the subject. A short time later, they located him in a backyard and took him into custody without further incident. Neither the officer nor the subject was injured.

MIRT Review and Analysis

The MIRT review generated three action items, addressing the use of K-9 units for searches like the one that ensued after the shooting here, best practices for booking spent Taser probes, and the need for a policy change regarding when less lethal shotguns should be loaded. Absent from the review was an objective examination of the officer's decision to fire his weapon. The Administrative Report adopts the officer's language with respect to his threat assessment but does not align that with the body camera footage.

For example, the report states that the subject "attempted to slam a wrought iron gate closed on [the officer]." In the video, the subject can be seen swinging shut one part of a two-sided swinging gate, a full second ahead of the time when the officer arrived. The officer did not change his stride to avoid it. Also, regarding the concrete block, the report recounts the officer's perspective that the subject threw the block at the officer in a way that posed a deadly threat. The video shows the subject throwing the block underhanded toward the officer, at a height of about the officer's knees.

While we do not discount the officer's threat perception or sense of vulnerability during this pursuit and the obvious danger he faced while pursuing the subject

alone, the available video also could support a conclusion that the subject's actions in both instances were intended merely to slow the officer's pursuit. The MIRT report did not present this alternative perspective, but instead focused only on what it characterized as multiple assaults on the officer.

Depending on the circumstances of the incident, the consideration of different but reasonable interpretations of specific actions could potentially bring value to the MIRT analysis. Here, it is quite plausible that (as he himself later asserted) the subject's actions were intended to aid his escape rather than to harm the pursuing officer. This in turn feeds into larger questions about tactical decisions that increase risk and make officers more vulnerable.

The officer's closing of distance intensified the threat posed by the thrown block and helped to prompt the shooting. Some danger is part of the job, and officers accept it knowingly. But when a safer approach can *coincide* with other legitimate goals – such as apprehension of criminal suspects who primarily just want to get away – these factors should be part of the conversation.

Unfortunately, the MIRT review did not critically examine the foot pursuit that preceded the shooting. The scenario presented here – a subject runs when an officer stops to speak to him – is a common one that often sparks the officer's instinctive reaction to give chase. The dynamic of most of these single officer pursuits, however, is inherently unsafe for the officer. The subject determines the path of the pursuit. If the subject is armed, he can draw the officer in and then turn and shoot the pursuing officer before the officer has an opportunity to react. Even worse, if an armed subject has an opportunity to turn a corner, jump a fence, or enter a building, causing the officer to lose visual contact, the subject then has a tactical advantage and can ambush the pursuing officer. A long foot pursuit can leave an officer (who is weighed down by the necessary gear on his or her belt) winded, and the exhaustion can compromise the officer's tactical skills and decision-making ability.

The dynamic of a solo officer foot pursuit is also unsafe for the public and the subject being pursued, as the heightened sense of danger faced by officers in this scenario may cause the officer to perceive any ambiguous move by the person being chased – such as grabbing at his waistband – to be an indication that the suspect is armed. Because officers are trained to anticipate lethal threats, the stress of a foot pursuit and insufficient distance between the officer and subject

sometimes causes an officer to use deadly force in response to perceived aggression when it turns out that the person being chased was not armed after all.

Guidance to police agencies and their officers on how to respond in these situations has evolved over the years, and many agencies have adopted some form of policy in an attempt to mitigate these risks. Beginning with our first review of APD officer-involved shootings, in 2015, we recommended that the Department develop a comprehensive policy governing whether and how officers should pursue subjects on foot, including factors to consider in deciding whether to initiate or continue a pursuit, and how to balance officer safety considerations with the goal of apprehending a suspect.

The Department recently adopted a comprehensive foot pursuit policy that is in many ways consistent with our original recommendations. The new policy instructs officers to broadcast their location and the fact that they are in foot pursuit. The policy also generally encourages officers to consider alternatives to a pursuit in certain circumstances, including when:

- The officer is alone.
- Officers become separated, lose visual contact with each other, or are unable to immediately assist each other should a confrontation ensue.
- The officer is unsure of his location or direction of the pursuit.
- The officer loses visual contact with the subject.
- The officer loses radio contact.
- Officers have knowledge the subject is armed.
- The subject enters a building, structure, confined space or isolated area.
- The danger to the officer or the public outweighs the necessity for immediate apprehension.
- The officer is disarmed.
- The subject's location is no longer known.
- The identity of the subject is established or officers have information that would allow for apprehension at a later time.

While the Department did not have any sort of restrictive foot pursuit policy in place at the time of this shooting, its training has for some time instructed officers on fundamental safety principles surrounding the question of when and how to

conduct foot pursuits.[14] Unfortunately, many of these important tenets of officer safety were overlooked in the MIRT review of this incident:

- The two officers intentionally split up, with the officer in the patrol vehicle almost immediately losing sight of his partner. When the pursing officer fired his weapon, his partner was not even aware that shots had been fired, where his partner was, or that he was in any kind of danger. Had the subject actually intended to attack the officer with the concrete block and successfully connected with the officer, the outcome here could have been tragic. The pursuing officer was clearly winded (as evidenced by the audio on his body worn camera) and may not have fared well in an all-out one-on-one fight with the subject. With no one aware of his location, he could have been on his own without backup for some time.

- The pursuing officer did not communicate that he was in foot pursuit and did not broadcast his location. Even after the shooting occurred, he merely (and unsuccessfully) broadcast, "shots fired," with no indication of who fired those shots. He did not broadcast his location for another 40 seconds, nearly a full minute after the shooting. Another 30 seconds passed before the officer gave a description of the subject and clearly stated he had fired his weapon.

- The pursuing officer closed the distance on the subject, and the circumstances suggest he would have tried to go hands-on and prevent the subject from getting over the block wall had the subject not turned to throw the block at him. Otherwise, he would have been on the radio while running, beginning to coordinate a containment to apprehend the subject, instead of getting close enough to be in harms' way while not communicating his whereabouts.

- As policy and training emphasize, an officer who is chasing a subject and properly communicating can continue to follow while coordinating the response of fellow officers to establish a containment of the area, attempting to trap the subject within a perimeter. A sound foot pursuit policy acknowledges that there usually are safer, smarter ways to apprehend

[14] Covering these issues in the training curriculum is important, but as we argued in our 2015 report, insufficient. Including the concepts in the newly-adopted formal Department policy messages to officers a heightened importance of compliance and provides the Department the ability to hold officers accountable if they violate policy.

> suspects and that forgoing the chase does not equate to letting the "bad guy" go. The fact that the subject here was apprehended later that day is testament to the value of communication and containment and evidence that the risks taken by the pursuing officer in closing the distance may not have been essential to accomplish the goal of taking the subject into custody. Indeed, had the officer begun communicating sooner, other officers may have been in position to more quickly apprehend the subject.

While we commend the Department for adopting a foot pursuit policy in general, and believe that is an improvement over its prior position, we believe the new policy could go further in promoting officer safety and encouraging accountability for officers who engage in unnecessarily risky pursuits. For example, many agencies have more restrictive policies that instruct officers that, when acting alone, they should not attempt to overtake and confront a subject but should instead keep the subject in sight while chasing and waiting for adequate resources to allow for safer apprehension.

We appreciate that the Department shared with us a draft of the new foot pursuit policy; we took the opportunity at that time to dialogue with Department leadership about concerns we had with that draft. And, in fact, some of the language we discussed was revised in the final version of the policy. We look forward to continuing to work with the Department on assessing future incidents involving foot pursuits and evaluating the effectiveness of the new policy.

> RECOMMENDATION 13: The Department should assess whether its new foot pursuit policy is meeting its goals of promoting increased tactical soundness and officer safety by reviewing and monitoring future pursuits, including officers' reasons for pursuing and supervisors' response to those incidents.

Shooting Case # 6

APD investigative personnel assigned to the Crime Task Force were in search of a murder suspect and received information that the man had kidnapped his girlfriend and was in San Diego. Investigators responded and found the man, who then ran from police. APD's air support unit recorded the man climbing a fence while an object fell out of his clothing. The video showed the subject trying to retrieve the object, but he was unable to do so because it had fallen on the other side of the

fence. A Crime Task Force member responded to the area and broadcast that the man had dropped a gun.

As the subject continued to run, an APD investigator drove after him. As the investigator got out of his car, he noticed the subject stop behind some bushes. The investigator gave commands to the subject to show his hands and identified himself as a police officer. The investigator was dressed in plain clothes, including shorts, but was wearing a vest that identified him as a police officer. According to the investigator, the man threw his hands up, but then started jogging away, with his hands still up. The investigator shouted at the subject to stop, but he responded by telling the investigator to shoot him, while continuing to run away toward the corner of a building.

As the investigator chased the subject (who was jogging with his hands up), the man rounded the corner of the building and slowed his pace. The investigator said that he believed the subject was "baiting him" and trying to draw him closer. The investigator said that he saw the subject's hands come down in front of his sweatshirt at which time he feared for his safety and the safety of the other task force members. The investigator said that he then fired four to six rounds.

The investigator said that he did not hear any radio transmissions after the subject started running because his window to his car was down and people were yelling. The investigator said he deactivated his body-worn camera prior to encountering the man because he feared the light on his camera would allow the subject to locate his position and target him.

The investigation revealed that the investigator had fired five rounds. One of the rounds entered the subject's buttocks and exited his scrotum. The subject survived his injuries. He was not carrying a weapon at the time he was shot.

The San Diego District Attorney found the use of deadly force to be justified. The opinion letter indicated that the air support video of the shooting did not clearly show that the man reached his arms and hands to the front of his body when he was shot, but that when played at a reduced speed, there were frames in the video where it was possible to see that the subject's arms were down as he ran to the location where he was ultimately shot.

MIRT Review and Analysis

MIRT reviewers determined the shooting was within Department policy, and identified one systemic issue relating to the policy on activation of body-worn cameras. The involved investigator de-activated his body-worn camera prior to engaging with the man. The MIRT review found that the majority of Crime Task Force members had not activated their cameras. APD policy at the time did not require investigators, detectives, and non-uniformed personnel to record contacts with the public and enforcement actions. To the Department's credit, as a result of this incident, the policy was changed to require activation of body-worn cameras for such personnel when engaged with the public or during enforcement actions.

In this case, APD did conduct an administrative interview of the involved investigator, but it was focused almost entirely on the investigator's decision to de-activate his body-worn camera. Indeed, the interview was intended to be done as a part of a separate administrative investigation on this issue, but the Department apparently never opened such an investigation, and thus never made a formal determination regarding whether the decision to de-activate his body-worn camera was a violation of policy or Department expectations.

The MIRT discussion considered the investigator's decision and discussed how body-worn cameras can be placed in "stealth mode" in which the light that concerned the investigator could be turned off while the camera was able to continue to function. However, despite this discussion, there was no action plan concerning this capability.

> RECOMMENDATION 14: APD should develop a supplemental review process to ensure that issues identified during the investigation and MIRT review are appropriately addressed.

The MIRT review failed to address other issues as well:

- *Threat perception.* APD found that the use of force comported with its deadly force policy, but issues that are relevant to that finding were not addressed in the analysis. There was no significant analysis into the precise actions made by the subject that resulted in the decision to use deadly force. As indicated above, the Air Support video shows that the man ran from the investigator with his arms outstretched. And even if the man lowered his arms at some point, APD failed to assess whether that movement

constituted a sufficient act of aggression to result in a justification for the use of deadly force. APD should have undertaken a more careful assessment in determining whether the decision to use deadly force based on these observations was consistent with its expectations.

- *The investigator's decision to go into a single person foot pursuit.* APD did not consider whether the decision by the investigator to get into a one-person foot pursuit increased the likelihood that deadly force would ensue. As noted above, at the time of the shooting the man was under surveillance by APD's Air Support plane. Officers could have developed a perimeter with the assistance of Air Support to more safely bring the man into custody.

  A one-person foot pursuit is inherently more dangerous to both the officer and the person being chased because it places the officer at greater risk and heightens his level of fear. And this foot pursuit was particularly dangerous considering the investigator was operating in unfamiliar territory, in plain clothes, with compromised radio communication capability, and without all equipment that a uniformed officer would normally have. Moreover, when the investigator lost sight of the subject, he reported that his fear was increased yet he continued to pursue instead of backing off, seeking cover, and moving to contain. As a result, when the subject made any move that the investigator believed increased the threat to him, such as merely lowering his hands, he was more prone to respond by using deadly force. APD failed to consider whether another tactical approach would have kept the investigator safer and decreased the likelihood that the incident would end with an officer-involved shooting.

- *Failure to hear critical radio communications.* Air Support observed and radioed that at one point the fleeing man jumped a fence, was briefly caught on it, dropped something, stopped to try to retrieve it but was unsuccessful, and then decided to leave it behind and continue his flight. Shortly thereafter, APD personnel radioed that they had located the object and that it was a gun.

  However, the investigator and other APD Crime Task Force members claimed that they did not hear the radio broadcast by their colleague that he had located a gun left behind by the man. In her analysis, the District

Attorney correctly noted that simply because the man had dropped one gun, it did not rule out his possession of additional firearms.[15]

Regardless, the knowledge that the man dropped a firearm would have been critical for all members of the Crime Task Force team to have. The fact that the majority could not recollect hearing the transmission raises a significant question about their ability to effectively communicate with each other – a significant issue in the midst of a fluid tactical operation. Despite this issue being prevalent during the MIRT discussion, there was no apparent effort by APD to explore it for the benefit of future Task Force operations.

RECOMMENDATION 15: The Department should identify and remedy any radio communications issues that arise during its review of tactical operations.

Investigative Issues – Criminal Investigation Reports

As part of its administrative review process, APD routinely obtains a copy of the Orange County District Attorney's investigative report and includes it in its review file. In addition, APD receives copies of tape-recorded interviews, video evidence, crime scene photographs, and transcripts of interviews.

In this case, however, the San Diego Police Department and the San Diego County District Attorney's Office conducted the criminal investigation. While APD collected some materials from that investigation it did not collect the actual interview of the involved APD investigator, copies of interviews of on-scene APD and San Diego Police officers, or body-worn camera footage of SDPD officers. As a result, there are significant gaps in the investigative materials APD possesses.

Collecting all the materials created as part of the criminal investigation is critical to an agency's administrative review of an officer-involved shooting. When this does not happen, it significantly hampers the agency's ability to evaluate the incident from a critical administrative perspective.

[15] However, she failed to include the man's attempt to retrieve the gun despite being pursued by law enforcement personnel. If the man had another weapon in his possession, he arguably would have been less likely to slow his flight to pick up an extra weapon.

RECOMMENDATION 16: APD should create written protocols to ensure that the complete criminal investigative file of the officer-involved shooting investigation is obtained and included in its administrative materials.

In-Custody Death Involving Force During Arrest Attempt

In this incident, officers responding to a call for service (involving a suspicious individual loitering outside the female caller's home) eventually ended up in a prolonged and difficult struggle with a 32-year-old male subject. The man offered intense resistance over the course of several minutes; then, as he was finally being handcuffed, he lost consciousness and never regained it. He died in the hospital after several days on a ventilator.

The two responding officers first spotted a man matching the reporting party's description and saw him enter a laundromat near the woman's home. Upon attempting to contact him, they heard broken glass that they believed might be a drug pipe he was discarding. He was agitated and started to resist immediately as they tried to take him into custody.

For approximately six minutes in the laundromat, followed by a foot pursuit across a busy street and then another encounter in a parking lot that lasted roughly four minutes more, the two officers (eventually joined by three others and a supervisor) tried multiple force options without success. These ranged from verbal commands to a significant amount of grappling and physical strikes to multiple Taser deployments and at least two applications of the carotid control hold. The suspect was large in stature and emotionally overwrought. He was also under the influence of methamphetamine at the time of the encounter.

When officers realized he had become non-responsive, they quickly shifted to a medical aid posture and attempted to revive him for several minutes before the arrival of EMT's. Nonetheless, the man did not recover. The autopsy determined that the cause of death was "complications of asphyxia" arising from his prolonged fight with the officers in conjunction with the effects of the drug in his system. The manner of death was ruled a homicide.

The District Attorney's Office reviewed the case criminally and released its findings some fourteen months later. In reaching its decision not to charge the officers with criminal wrongdoing, it was able to rely on body-worn camera

recordings from the primary officers as well as additional personnel who arrived at the parking lot. There was also surveillance camera evidence from inside the laundromat, witness statements from multiple observers, and voluntary testimony from the officers themselves.[16]

The District Attorney analysis looked at the different forms of criminal homicide and the legal standard for each. The evidence established the subject's intense level of agitation and his physical resistance to the officers, and it seemed clear that there was no intent on the officers' part to do anything more than achieve compliance and take him into custody. However, it was also true that *deadly* force was not warranted by the subject's actions. He was unarmed and his violent struggles were simply in service of a panicked attempt to get away.

This meant the question of legality in many ways reduced to whether the officers were criminally negligent – that they breached a duty of care to the suspect by causing his death through conduct that was unacceptably and foreseeably dangerous. The District Attorney determined that they had not been. Instead, it pointed out that the carotid restraint was an authorized level of force in light of all that had occurred, that its second application had been closely monitored by the sergeant who arrived on scene, and that the officers had moved swiftly into rescue mode once it was clear that the subject was in medical distress.

MIRT Review and Analysis

Uncharacteristically, the initial MIRT presentation to the executive command did not produce a single action item. The subsequent assessment was also largely straightforward. Only one officer was interviewed administratively,[17] for example, and the resulting analysis – which found officer conduct to have been in

[16] The officers who used force on the subject were interviewed five days after the incident and were allowed to view the video evidence prior to being interviewed. To repeat, those interviews should have occurred on the date of the incident and the officers should not have been exposed to video footage prior to providing a pure statement of their actions and observations.

[17] This occurred immediately after the voluntary interview with criminal investigators cited above. This timing is a strategy that some agencies employ, in an effort to streamline the process for involved personnel and reduce the likelihood of multiple statements that produce understandable – but problematic – discrepancies. These reasons make sense. But fatigue and investigator sensitivity also have the potential to limit the second interview's scope and level of detail. In other words, these factors impose a sort of "cost benefit" analysis on decisions about whom should be interviewed and how thorough the questioning should be. Indeed, the bristling by the officer's counsel about repetition was noteworthy on this occasion. And it was disappointing that administrative interviews of other key participants did not happen at all.

policy – lacked the kind of rigor and thoroughness that the process produces at its best.

One example of a missed opportunity was inadequate follow-up regarding an issue that was at least and identified and discussed at the initial presentation: namely, the expressions of concern by the subject's family about the difficulties they experienced in terms of hospital access and information. There is no documentation of further inquiry or a formal response to the concern. Moreover, body camera footage from an officer assigned to the hospital showed a lengthy exchange with upset relatives – and an imperious approach by the officer that presumably fell well short of the Department's preferred approach.

Confusion or tension with family members in the aftermath of a critical incident is a dynamic that can be hard to avoid, given the imperfect fit between investigative or security imperatives and the understandable emotions of affected relatives. Making it seamless is probably not possible. But having a plan and relevant policies, and prioritizing clear, effective communication, should be goals that the Department can work to attain.

> RECOMMENDATION 17: The Department should revisit its protocols and training regarding the best approaches to communicating with family members of the subject in a critical incident scenario, and should appropriately investigate complaints that arise from these situations. Included in this review should be whether APD should assign personnel unaffiliated with the investigation to serve as a liaison for the family of individuals seriously injured or deceased as a result of police actions.

The other glaring question that seems to have gone largely unanswered here is what, if anything, the officers could have done differently. The finding of no policy violation as to the force is colorable – if not completely clear cut in our view. The struggle was prolonged and violent; and the subject was considerably larger than the officers, impaired by drugs, medically compromised to begin with, and strikingly agitated and uncooperative. We recognize that the situation was a very challenging one, and that arresting him in the interest of public safety was a valid goal. However, stepping back to consider alternatives – even if none would

have been certain to improve the outcome – seems like a worthy exercise that does not seem to have occurred. [18]

As for the carotid control technique that figured prominently in the incident, and may have contributed to the final result,[19] we have urged the Department in the past to revisit its authorization of this controversial force option. The Department counters by pointing out its distinctive value in certain "close quarters" struggles with resistant individuals. It cites the potential benefits of effective deployment (including safety for officers *and* subjects), and points out the safeguards built into policy and training that are meant to mitigate the inherent dangers of neck-centered, airway-adjacent force applications.

In our numerous conversations with officers, Department management, and training staff members regarding this topic, we know that they have a good faith belief in the importance of preserving the carotid hold as a force option. But incidents like this reinforce the difficulties of successful application in a volatile environment. We urge the Department to institute a formal and rigorous assessment of deployments in the last several years, and to ensure that the training it provides accurately reflects the degree of difficulty and potential consequence.

> RECOMMENDATION 18: The Department should formally review the most recent five years' worth of carotid control hold incidents to determine whether its inherent dangers continued to be outweighed by the overall effectiveness of the technique, and to explore the advisability of ending authorization of the hold, or at least only allow it when deadly force is authorized.

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[18] Nor were the involved officers alone in needing further remediation: the sergeant who arrived on scene at the end of the encounter continues to encourage officers to apply the hold even when they are struggling with effective application and can be heard at one point saying "Hold that choke" as the final application continued. The common "chokehold" terminology is itself reflective of the problematically fine line between a safe, effective technique and a dangerous one. It is obviously important for supervisors to recognize and reinforce this distinction through clear language.

[19] The subject suffered both internal tissue damage and a fractured neck bone, potentially caused by the carotid holds, and he audibly gasps at various points in the two different attempted applications. These are indicia of problems that should not arise when the hold is working optimally, and as trained.

In-Custody Death: Off-Duty Intervention

This incident began early in the morning when the subject boarded an Orange County Transit Authority bus and, when asked for the fare, told the driver she was homeless. The driver allowed her to remain on the bus and continued on her route. The subject went to the rear of the bus. After the bus had driven a short distance, the subject opened a window, climbed out feet first, and fell or jumped onto the street, striking her head on a curb. According to witnesses, she lay motionless for several seconds before jumping up and running through traffic while yelling and screaming. She climbed onto a couple of vehicles, jumping on the hood of one, the trunk of another, and into the truck bed of another. She retrieved a metal pipe from the truck bed and climbed onto the roof of the truck. Two bystanders intervened and led the subject to the sidewalk, attempting to keep her out of traffic.

Some witnesses called dispatch and both Police and Fire personnel were en route to the scene when an off-duty sergeant drove past in his unmarked police vehicle on his way to work. He exited his car and tried to talk to the subject, who was clearly agitated and bleeding from the head. She lunged toward his car, and he grabbed her right arm. As she struggled to free herself, he took her to the ground and held her there, her arm behind her back and his knee in the center of her back. The subject complained at times that she could not breathe, and the sergeant would remove his knee, only to have her begin struggling to escape. Because he was off-duty, he did not have handcuffs or any means to secure her other than his physical force.

An on-duty officer arrived approximately two minutes after the sergeant first engaged the subject and quickly handcuffed her. The subject continued to complain that she could not breathe. Within a minute, the officers had rolled her onto her side. Less than two minutes after the on-duty officer arrived, the subject became unresponsive, and the officers moved her into a seated position to try to rouse her. The officer stated he felt a faint pulse and observed shallow, weak breathing. Paramedics arrived approximately four minutes after the on-duty officer arrived and reported that the subject was not breathing and had no pulse. She was transported to the hospital, never regained consciousness, and was pronounced dead the next day.

The Coroner's office determined the cause of death to be acute methamphetamine intoxication. The District Attorney closed its inquiry in the incident with the

determination that there was no evidence of criminal culpability by any APD personnel.

All of the witnesses described the subject as being either intoxicated or in a mental health crisis. None reported any concerns of unnecessary force or complaints about the officers' conduct. A portion of the incident was captured on a bystander's cell phone video, and the arriving on-duty officer recorded the remainder on his body-worn camera. The video was consistent with officer and witness statements.

The MIRT process proceeded as usual and identified no issues with the incident. There were potential concerns with the subject's positioning while being restrained by the sergeant, but the Department believed the officers' statements and coroner's findings adequately addressed those concerns. Both the officer and the off-duty sergeant had attended training on excited delirium and positional asphyxia within the prior year.

One notable issue not raised in the MIRT review was the off-duty sergeant's decision to engage with the subject. By deciding to take law enforcement action, the sergeant essentially put himself on duty, and his conduct was held to the same standard as an on-duty officer. We do not question the wisdom of that decision and in fact find the sergeant's willingness to engage to be laudable. The subject was in clear danger and was posing a danger to others, some of whom were already attempting to defuse the situation, and failing to act could have created additional risks.

Nonetheless, it's worth discussing the ways in which an off-duty officer is limited relative to one who is in on duty in full uniform. The off-duty sergeant was not equipped with any of his usual tools – gun belt, OC spray, Taser, or handcuffs – and therefore had fewer options for controlling the subject as this incident unfolded.[20]

We have seen a dynamic develop in tragic ways in a number of other agencies and incidents, where an off-duty officer decides to take action in a situation where it might have been more prudent to wait for better-equipped officers to respond. We understand the pull in various directions – officers are trained to take action and it

[20] Obviously, he also was not wearing a body-worn camera, providing a more limited opportunity for review.

may be difficult to overcome the instinct to intervene – and again do *not* mean to suggest that the sergeant involved in this incident should have stood by and waited. Nonetheless, commendable performance can serve as a valuable lesson, and this incident could have provided a useful training tool to discuss with officers the pros and cons of off-duty engagement. [21]

> RECOMMENDATION 19: The Department's analysis of off-duty force and/or arrest encounters should reflect an emphasis on the special challenges of such actions, and individual incidents should prompt training bulletins and reminders as needed.

Shooting at Dog Incident

Shortly after midnight, officers responded to a residence regarding a loud music complaint from neighbors. They walked down a driveway into a backyard, where the residents were cooperative and complied with the request to turn down the volume. As officers were walking back down the driveway to leave, two dogs ran at them from the backyard. (The dogs had apparently been inside the house at the time the officers were interacting with the residents.) As officers attempted to kick at the dogs to keep them away, one officer fired three rounds at one dog, a 27-pound pug mix. The dog was struck but survived his injuries. The other officer was able to kick the other, similarly sized dog off of his leg, and did not fire his weapon. Both officers sustained minor bite wounds on their calves.

The MIRT team prepared an Administrative Review but did not convene the usual MIRT meeting or presentation. In this case, the then-Chief determined a full presentation was not necessary after reading the MIRT report.

The Review identified no recommendations or issues of concern. It found the shooting to be consistent with APD policy, which authorizes the use of a firearm to stop a dog or other animal where the dog "reasonably appears to pose an imminent threat to human safety and alternative methods are not reasonably available or would likely be ineffective." The policy also requires officers to

[21] Department executives have shared with us the assertion that these kinds of constructive de-briefing discussions are happening informally and on a regular basis in response to incidents like this one. We consider this both believable and noteworthy – but still think the formalizing and documenting of such moments is an attainable goal worth pursuing.

develop a plan to avoid deadly force when they have advance notice that they may encounter a potentially dangerous animal.

Here, the dogs (though relatively small) had previously been reported to Orange County Animal Care for their aggressive behavior, but those reports tied the dogs to an address next door to the home that was the subject of this call. The officers initially entered the property without encountering the dogs, or even hearing them bark, and were surprised when the dogs charged out at them as they were leaving the property. One dog persisted through the officer's initial attempts to kick it off his leg, leading one officer to conclude that the dog posed an imminent threat that he had no other reasonable means to stop its aggression.

The incident was captured on officers' body worn cameras, though the scene was dark and it is difficult to see the dogs clearly. Following the shooting, numerous officers responded to assist and activated their body worn cameras. As a result, most of the video footage associated with this incident captures the aftermath of the shooting, when the on-scene officers dealt with angry (and in some cases intoxicated) residents who were upset about the shooting of their dog and wanted the officers to leave their property.

Officers needed to remain in the yard to secure the scene and ensure access for the sergeant and others who arrived shortly after to conduct an investigation into the circumstances surrounding the shooting. Officers generally did a commendable job of using restraint to contain the potentially antagonistic encounter, with one officer in particular remaining calm and making efforts to explain to the most calm and sober resident their reasons for remaining on the property. Unfortunately, one officer was less restrained, and at one point used profanity and some heated language toward the dogs' owner.

Unfortunately, this aspect of the incident was not addressed in the MIRT review. As we have said repeatedly in prior reports, the most meaningful review of a shooting or any critical incident looks holistically at the entire encounter for ways to improve officer performance or institutional preparedness. Regardless of any accountability measures for the one officer's profanity, this incident presented a learning opportunity and could have been used as a training example for managing a loud and potentially hostile group in an emotionally charged atmosphere. We have in the past congratulated the APD for using its MIRT process to identify issues and develop action plans to guide officers in future similar encounters. This incident represented a missed opportunity for such productive self-critique.

RECOMMENDATION 20: When an incident becomes the subject of a MIRT review for whatever reason, the Department should ensure that it maintains its usual commitment to holistic review and investigation, and responsive action items and remediation.

Other MIRTS: Review of Critical but Non-shooting Cases

The MIRT process has evolved over time to encompass non-shooting incidents that are nonetheless serious in their consequences, public interest level, and/or potential for learning opportunities. Four of the cases that were completed during the review period related to traffic accidents that resulted in serious injury or death to involved parties. We summarize each of these below, with a focus on the Department's administrative findings and action items.

Incident # 1: Traffic Accident with Fatality

We rolled to a case in which a vehicle pursuit through city streets resulted in the suspect vehicle crashing into the corner of a business. Neither of the two remaining passengers was injured, and the driver was taken into custody and charged with multiple felonies – including drunk driving. Moments before that outcome, however, a fourth passenger had tumbled from the moving vehicle during the pursuit and fractured his skull upon impact with the street. Days later, he died in the hospital from his injuries without regaining consciousness.

This incident began in the early evening of a weekday when uniformed officers assigned to a gang suppression detail spotted a car with four young men inside who had a "gang appearance." They chose to follow in their own marked car, eventually turning on lights and sirens as the vehicle fled. At one point they spotted "possible narcotics" being tossed from the car; the object was not recovered.

When the passenger fell – or was pushed – from the suspect vehicle, the officers put it out on the radio and then continued in their pursuit, which lasted a total of two minutes before culminating in the collision. It was other officers who responded to that first scene within a few minutes of the initial "man down" notification and rendered aid until an ambulance arrived.

The District Attorney's Office did not respond and did not treat it as an "in-custody death" for purposes of its protocol. However, because of the severity of the injuries to the man – and an initial witness report that the officers had possibly run him over – the Department asked for a full MIRT response. The investigation eventually revealed that the man's injuries were not consistent with that kind of trauma, nor was the claim supported by other evidence. (The body-worn camera recordings only show the interior of the officers' car during the pursuit; however, the audio is consistent with no such contact occurring. As for the remaining parties in the suspect vehicle, they were interviewed but did not provide particularly detailed or illuminating information.)

MIRT Review and Analysis

As suggested by the District Attorney's lack of involvement, this was an unusual fact pattern for the MIRT process. Accordingly, the arrival of MIRT investigation personnel was confusing – and perhaps even disconcerting – to the involved officers and others on the scene.

The circumstances led to other procedural glitches as well. Given the involvement of its officers in the incident, the Department asked for assistance from the California Highway Patrol in handling the accident investigation and the criminal DUI case against the driver of the suspect vehicle. However, this was slow to come together and resulted in some tension and uncertainty in the field in the crash's aftermath. Fortunately, the CHP eventually did take the lead, thus preserving an appropriate independence in the analysis, but the initial delay and communication issues warranted further management attention.

Perhaps as a function of the unique circumstances, the resulting MIRT presentation was relatively straightforward – and no action items emerged. The MIRT team eventually did an analysis of the pursuit itself and found that it was consistent with Department policy.[22]

From attending the MIRT review and watching the body camera recordings, we noted one element that perhaps merited further attention: the multiple profanities directed by officers at the car's occupants in order to safely take them into custody after the crash. This is a recurring topic of interest for us.

[22] See below for further discussion of pursuit cases and the MIRT process.

We recognize the realities of the tense, adrenalized situations that officers encounter, and we give some credence to the assertion we frequently hear from law enforcement about the effectiveness of strong language as a form of "command presence" that facilitates compliance. But we nonetheless maintain that there is a fine line between "tactical" profanity and the gratuitous or "out of control" versions of the same language. Moreover, such instances – observed by witnesses or played back in public in a range of potential contexts – still clash with public expectations for police professionalism.

We don't advocate a draconian or even a necessarily formal response to these episodes when they occur. But explaining them away too readily, or shrugging them off as simply part of the job's rougher edges, also seems less than optimal.[23]

Our other takeaway from this incident is the opportunity it provides to reinforce an inclusive philosophy for utilizing the MIRT process across a range of critical events. We consider APD's MIRT protocol, and the skills of its investigative personnel, to be significant assets to the agency. At their best, the MIRT assessments are a thorough, *constructive* form of self-review that enhance Department performance in a variety of ways. And, while being mindful of resource limitations and concerns about overloading the MIRT staff, we think the Department's leadership should look for *more* opportunities to utilize the process rather than limiting it to a narrow few categories.

The unease – and subsequent questions – about MIRT's involvement in this incident suggests that there is room for further education and clarification as to MIRT's role. The Department took a positive step in this direction this year by creating a "mock MIRT" incident, complete with video of a deadly force scenario. It then presented it to an audience of APD members in an effort to show how the process works.[24] We thought the presentation, which we saw, was excellent and very worthwhile.

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[23] Moreover, the profane yelling at the suspects in this case also ran the risk of being confusing and/or contradictory: orders to "show hands," "don't move," and "get on the ground" within seconds of each other , and laced with profanity, could theoretically lead to inadvertent misunderstanding in the tension of the moment. This was mentioned during the MIRT presentation but not pursued subsequently.

[24] To its credit, the Department also offered the presentation at one of the PRB's public monthly meetings.

RECOMMENDATION 21: The Department should consider more effective ways to respond to officer language and demeanor issues when they emerge in the context of the review process.

RECOMMENDATION 22: The Department should utilize its MIRT protocol in a wide range of situations, and continue its efforts to educate all personnel and its public about its purpose and potential benefits.

Incident # 2: Traffic Accident with Injury

This review concerned the high-speed pursuit of a stolen vehicle that ended in a serious crash, resulting in injury to the suspect driver. The crash occurred in the context of a "PIT" maneuver by the involved officer.[25] The suspect vehicle veered into the center divider and struck a tree, causing the car to split and ejecting the driver into the road, where he then received medical aid from the officer and then medical responders. He was hospitalized and eventually released to face criminal charges in the case.

The pursuit was initiated in response to a surveillance operation by investigators that identified the suspect vehicle as stolen. A marked patrol unit was assigned to conduct a stop, but the driver did not yield and the pursuit began. It ended up involving multiple police cars (including one supervisor), lasting some five minutes, covering approximately four miles, and reaching speeds of 80 mph. At one point the suspect caused a hit and run collision with a third-party vehicle; at another, another attempted PIT maneuver stopped him only momentarily.

The initial MIRT presentation occurred within a couple of weeks of the event, and a few different action items emerged. The first related to reinforcing the standards for permissible use of the PIT maneuver. The second involved a training bulletin about the influence of mental and physical fatigue on officer performance (in light of the involved officer's extended on-duty time in the 24 hours preceding the incident). Finally, the Executive Command called for a general review of the APD pursuit policy, techniques, and operations.

[25] The "pursuit intervention technique" (or "PIT") involves deliberate contact between the police car and the suspect vehicle that is intended to end a pursuit by causing the suspect vehicle to spin out.

Additionally, the Department eventually ordered an Internal Affairs investigation into the involved officer's compliance with policy. The key issue was the speed at the time of the collision with the suspect vehicle. While PIT training expressly calls for limiting attempts to speeds less than 35 mph, evidence from the accident investigation suggested that both cars had been going faster at the point of the contact.

The Department's review had some strong features. The action items as identified were thoughtful and appropriate, and the investigation into the accident ultimately revolved around findings and conclusions from an independent expert's assessment. The Department was right to initiate an administrative investigation into the officer's performance, and its finding (that the speed had been excessive, and that the PIT was therefore out of policy) was supported by the facts.

Other aspects of the response were less effective. One of these was the extremely mild disciplinary consequence for the officer – an issue we cited in our 2018 report as an example of the occasional incongruity between the severity of transgressions and the Department's remediation.

Another was the long delay in finalizing the MIRT process – some two and half years for an incident that did not even entail a District Attorney investigation into officer conduct. There were some explanations for this (including a long waiting period during the pendency of an outside expert's review, which was unusual but valuable). And it should be noted that – as is often the case – some of the substantive aspects of the APD response were done in a timelier fashion, even if the formalities of concluding the case were slower to occur.[26]

The Department's response to the third MIRT action item had notable strengths. This was the assignment to convene a working group for the purpose of reviewing the Department's pursuit policy and "pursuit related operations," expressly for the purpose of making potential recommendations for changes in the APD approach.

That group appears to have performed its role in a timely and thoughtful way. Though it recommended leaving current policy intact, the group articulated its rationale for doing so – and offered some worthwhile suggestions about how to enhance safety and performance within the parameters of those existing standards.

[26] Here, for example, the Department issued the relevant training bulletins within weeks of the initial MIRT presentation.

Perhaps most significantly, the group expressly called for a broad-based analysis of each pursuit, including "judgment, tactical skills, and compliance with policy."

The Department's response in this case was appropriately thorough in some ways. But it fell short with regard to analysis of the pursuit itself,[27] and with regard to the larger questions of whether and how adjustments should be made. Given the seriousness of this crash and the potential for severe, permanent injury that it presented, the absence of rigor here becomes more conspicuous.

This is not a new concern from our perspective, and we made recommendations regarding these issues in our last report. Below, we discuss a more recent pursuit. Vehicle pursuits are a high-risk activity that – as the APD memo itself indicates – often result in collisions and injuries. Accordingly, they merit a high level of close review and administrative attention. We look forward to incorporating vehicle pursuit issues into our regular audit activities – and plan to research more directly the effects of the working group's insights and commitments in this area.[28]

> RECOMMENDATION 23: The Department should give administrative attention to the mechanics of closure for MIRT action items, to help ensure that the intended review and outcomes are occurring.
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> RECOMMENDATION 24: The Department should continue the training and evaluation efforts that arose from its most recent study of vehicle pursuits, and should remain open to revisions of policy as needed in light of individual incident review (and per the study's recommendation).

Incident # 3: Traffic Accident with Injury

Shortly after midnight, an officer observed a large SUV drive through an intersection without stopping for a red light. The officer initiated a traffic stop, and the driver of the SUV slowed and began to pull to the side of the road, but then accelerated away. The officer activated his lights and siren and pursued the

[27] The Pursuit Critique by the handling sergeant that is required by Department policy was not included in our materials, if it did occur at all.

[28] In the meantime, we note with interest that the Department has recently experienced a significant decrease in the total number of pursuits by its officers.

vehicle. He had not yet obtained the license plate number of the SUV, and did not learn until later that the SUV had been reported stolen the day before.

The SUV reached an estimated speed of 60-70 miles per hour and the officer fell behind as he drove a bit more slowly. Around 45 seconds later, the driver lost control of the SUV as he swerved to avoid a vehicle and then collided with a parked minivan. The driver was thrown from the vehicle and sustained serious but not life-threatening injuries. An individual sleeping in the parked van suffered a lower back injury.

The officer's initial broadcast was for a vehicle stop. He subsequently announced the failure to yield and the subject's route of travel, noting that there was no traffic. Fifty-one seconds after the initial radio communication, the officer broadcast the collision. He was a block to block and a half behind the subject's vehicle at the time it crashed.

The pursuing officer requested paramedics and waited for backup to approach and clear the SUV and detain the subject. The subject was in obvious pain and bleeding heavily from his rectum, and officers provided appropriate assistance while waiting for paramedics.

The MIRT review focused on the officer's compliance with the APD policy governing vehicle pursuits. That policy generally requires officers to balance the need to apprehend the subject against the risks associated with the pursuit, weighing factors such as traffic and road conditions, presence of pedestrians, the subject's speed, seriousness of the alleged crime, and likeliness of apprehension at a later time.

Here, the officer reported there was no traffic, and he regulated his speed to maintain visual contact with the subject vehicle while he waited for the requested aerial support to arrive. The officer had not yet identified the subject or realized that the SUV had been reported stolen. This cuts different ways, of course. The officer did not know who he was chasing and based his pursuit only on the observed traffic violations, but could infer there was a more significant motive for the subject's flight and had no way to later apprehend him.

Given the short time and distance of the pursuit – 50 seconds covering three-quarters of a mile – there was little grist for the MIRT review mill. After a perfunctory review that nonetheless considered all relevant factors, the Department concluded the pursuit was within policy.

What is notable about this incident is its inclusion in the MIRT review process. In our last report, we were critical of the Department's lack of rigor in reviewing a lengthy vehicle pursuit involving numerous officers that culminated in a serious traffic collision. There, we found the Department's vehicle pursuit critique overlooked several significant elements of the pursuit that were relevant to its effectiveness and eventual outcome. We urged the Department to consider using the MIRT process to analyze vehicle pursuits and to make them a category for outside oversight. Subjecting this pursuit to a full MIRT review and presentation enhances the quality of the Department's review in this topic area.

Incident # 4: Non-Hit Shooting by Off-Duty Officer from Outside Agency

On a weekday afternoon in 2017, an off-duty police officer from another jurisdiction confronted several middle-schoolers who were walking home through his Anaheim neighborhood and cutting across his property. The conflict escalated, in part because of past issues, and after some fifteen minutes of confrontation involving the man and numerous young people, a physical tussle culminated in the officer firing a gun into the ground in what he characterized as an act of self-defense.

The man's father had initially placed a call to 911 well before the shooting, but APD officers did not respond until shortly afterwards. They ended up handcuffing and then arresting one of the teenagers based on the off-duty officer's representations, while he was neither cuffed nor arrested in spite of having used his weapon.

Some of the teenage witnesses had recorded the lengthy confrontation and its aftermath through cell phone videos. These were quickly posted on the internet story began to circulate rapidly through social and mainstream media as a dramatic instance of adult overreaction – a concern that intensified when it became known that the man was a police officer.

Public criticism concentrated into a protest the following day in the same neighborhood; a group of some 200 individuals – some of who were unruly – gathered in the evening near the site of the shooting. While the off-duty officer was the primary target of the demonstration, the larger conversation incorporated

questions and challenges about APD's response, and whether it had improperly taken the officer's side.

APD monitored the situation closely, working to balance the right to protest against concerns about maintaining safety and order. Eventually, after the gathering had lasted for more than two hours, the Department utilized a "mobile field force" to disperse the crowd, and several individuals were arrested. A few different local agencies offered assistance in the crowd dispersal.

To its credit, the Department and City responded to the high level of public interest in the incident by holding a press conference two days after the non-hit shooting. It provided some useful information from the early stages of the investigation, and acknowledged the extent and legitimacy of community concerns.

The District Attorney's Office reviewed the incident and ultimately declined to press charges against the officer for his actions. (He was also investigated administratively by his own department for the use of force and related conduct.) The juvenile, whose disputed comment toward the officer was supposedly a basis for the man's perception of threat and attempt to detain, was also not charged.

MIRT Review and Analysis

There were positive aspects to the APD response to this controversial incident and its collateral features. Some of these related to the handling of the protest that developed on the second night. The Department tracked social media to gather information and put together a plan that sought to balance respect for speech rights with appropriate safety and security issues. Recognizing the hostility toward law enforcement that pervaded the crowd, the Department pulled back to re-organize after its initial contacts. And, after some early communications issues, APD eventually coordinated resources and gathered a "Mobile Field Force" to address crowd control. The demonstration itself lasted for approximately two hours, and the units that ultimately dispersed the participants were organized and effective. And, as mentioned above, the City's recognition of the public's interest led to a helpful press conference the next day that brought together police personnel and a range of city officials (including the Mayor) to address questions.

Strangely, though, the Department's use of the MIRT process was halting, inefficient, and ultimately unsatisfying. After considerable vacillation, the executive command finally authorized a MIRT review – but the initial meeting did

not occur until several months after the incident. This delay undermined some of the significant advantages of the MIRT format. These include timeliness and clear coordination when it comes to identifying issues of various kinds and ensuring the proper administrative response.

The cases did lead to two Internal Affairs investigations into potential performance issues. The first related to the performance of the Dispatcher, who was found to have erred in not summoning a more urgent response after receiving the initial 911 call from the off-duty officer's father.

The other misconduct case related to the failure of investigators to use body cameras and record their service of an evidence-gathering warrant during the follow-up investigation. This occurred a few weeks after the original incident, and resulted in a scuffle with the juvenile witness whose cell phone video was the subject of the warrant. He was eventually detained and brought to the APD station for questioning.

The four detectives in question were indeed in violation of a new requirement that they wear and deploy body cameras in the context of a certain investigative encounters. Each received a very low-level consequence for the violation. Unfortunately, the lack of body camera evidence of the encounter had a larger significance: the involved individual filed a legal claim relating to his treatment that day, and the absence of a recording left a significant gap in the Department's ability to respond.

Another disappointing feature of the Department's administrative response related to one of the major sources of public criticism: namely, the seeming favoritism with which the responding officers had treated the adult who fired the shot, as opposed to the juvenile he was seeking to detain. There was arguable justification for this, given the nature of the 911 call they received and the desire of the off-duty officer to make a citizen's arrest of the juvenile for his alleged threat.

Still, the age, size, and aggression disparities – and the man's status as a fellow officer – created legitimate questions about bias and the overall soundness of the officers' assessment and decision-making. Though repeated questions about this emerged during the review period (including by OIR Group in the context of the MIRT presentation that finally took place), and though there were assurances that it was being evaluated, no documentation of a formal response has been provided.

This seems like a missed opportunity, and a further element in an uncharacteristically inefficient MIRT process.

> RECOMMENDATION 25: The Department should amend its MIRT policy to formalize a commitment to using the review process to analyze high profile and multi-faceted incidents, including those that raise outside concerns about the Department's handling of the incident.

> RECOMMENDATION 26: The Department should pursue training opportunities to address the unique issues that arise when dealing with off-duty law enforcement personnel in the context of potential criminal conduct.

The KKK Rally and APD Response: A Missed Opportunity for Improvement

In early 2016, the KKK held a publicized rally in an Anaheim city park. Counter protesters arrived at the location and a violent confrontation ensued. Ultimately, there were injuries and arrests that resulted from the clash.

Almost immediately, concern emerged about various aspects of the incident, including APD's handling of it. The most serious charge was that the lack of a uniformed officer presence at the protest site provided the opportunity for violence to occur with impunity, and that the Department's planning and allocation of resources were therefore blameworthy.

In response to this criticism and in light of the incident's notoriety, at least one command staff member recommended convening a MIRT "after action" meeting for purposes of analyzing what had occurred and determining whether accountability or other interventions were warranted. However, the suggestion was rejected. Instead of the more comprehensive, formal, and established MIRT process, a brief After-Action Report of the incident was prepared by one of the supervisors involved in the original planning.

This Report concluded that APD did a number of things well. At the same time, it did include the following observations as potential lessons for future improvement:

- "*We have experienced that during protest events a visible presence of officers tends to escalate and agitate the protest crowd. However, in this instance, because it involved 2 opposing protest groups, an initial visible presence of officers may have assisted in deescalating the situation before it became violent."*

- *"The importance of being aware and utilizing careful discretion in communications (telephone messages, e-mail, text, etc.) regarding these types of events."*

This analysis was a gesture in the direction of useful internal review. Meanwhile, however, community focus on the rally – and questions about APD's actions – persisted. At some point, the Department's then leadership made public remarks about the incident, including at City Council and before the Police Review Board. This prompted a resident of Anaheim to allege that those public comments were false and misleading regarding the "time sequence" of what APD knew about when the demonstration was scheduled to occur. The complainant suggested that the misleading public statements were made to deflect any criticism that APD insufficiently prepared for the demonstration.

Instead of immediately referring the complaint for an outside investigation, as would have been advisable given the nature of the allegations, the City assigned the matter internally. That review concluded that the complaint was unsubstantiated. At best, however, this "investigation" offered only a surface level inquiry into what had transpired and fell well short of addressing all the concerns raised in the initial complaint. In short, the initial review of the complaint lacked the thoroughness and objectivity that should be a goal of all complaint investigations.

Eventually, the City did assign the matter to an outside investigator for a formal and comprehensive investigation. However, because by then almost a year had gone by, the investigator had limited time in which to collect the facts. Despite this challenge, the investigation was creditable and resulted in a finding that no sustained violations of policy had occurred. But it solely addressed the allegations of misleading public statements that were the subject of the citizen complaint, rather than the broader and underlying questions about APD's deployment decisions.

The halting, inefficient, and narrow unfolding of this review served to reinforce the extent to which the initial decision not to utilize the MIRT process was a serious misstep. The controversy and violence connected with the rally received national attention, and the incident was sufficiently high profile to justify further self-assessment by APD – even without the public questions about the efficacy of its decision-making. Instead, the review that did occur left a number of important issues unresolved:

- What were the strengths and limitations of the Department's initial deployment strategy for handling the demonstration?
- Was APD's concern about having a uniformed presence in the park sufficient justification for the delayed response, especially in light of the violence that unfolded?
- Did the lack of uniformed personnel in the park result in difficulty in successfully identifying and apprehending the perpetrators of violence?
- What foreseeable alternative strategies could the Department have used, and how might it better prepare for and respond to similar future conflicts?

If a MIRT had been convened, the incident would have been more fully vetted and these questions and others could have been creditably answered. While the After-Action Report identified some concerns about planning and deployment, an involved supervisor's brief assessment will inevitably fail to match the normal MIRT process for depth and thoroughness as a result of participation by APD's command staff and specialized units. Moreover, as we have explained before, the MIRT process also provides a multi-faceted mechanism for uncovering the facts and decision-making behind the incident; as a result, it offers a superior opportunity for self-reflection and self-criticism. And, at its best, the MIRT process produces significant insights that enhance future performance in various ways.

In this instance, because that degree of analysis and critique was not done, APD missed out on chances to learn from the KKK event in systemic, Department-wide ways. And by rejecting the suggestion to convene a MIRT, APD's leadership lost a messaging opportunity with regard to its commitment to self-scrutiny. It also invited questions both within and outside the Department as to whether potential criticisms were being inappropriately muted because of the APD personnel who may have been involved in the pre-planning decision-making.

A timely and comprehensive MIRT assessment might also have prevented the concerns about inaccurate public statements that ultimately gave rise to the citizen complaint. The process would have created an accurate timeline to reduce confusion about "what APD knew, and when it knew it." When questions are raised about police response to a serious event, it is essential that the agency be painstakingly accurate about any information it releases. While outside interest and demand for immediacy creates understandable time pressure, agencies still need to vet facts carefully and ensure the accuracy of any reports released to the public by its representatives. And when information does get released that later proves to be inaccurate or potentially misleading, the agency must promptly and readily "correct the record" with an accurate account.

In short, APD's handling – for better or worse – of a volatile public demonstration was a worthy subject for comprehensive review. The agency's choice not to use its best vehicle for performing that review constituted a lost opportunity to improve its own performance and assuage understandable public concerns. As we recommend above (Recommendation 25), formalizing the criteria for MIRT reviews will help eliminate situations like this in the future. We make two additional recommendations stemming from our review of this incident:

> RECOMMENDATION 27: APD should reinforce the critical importance in ensuring that information publicly communicated about an event be entirely accurate.
>
> RECOMMENDATION 28: When publicly disseminated information about a police involved event proves misleading or inaccurate, APD should move promptly and readily to correct any confusion.

Internal Affairs Investigations

High-profile incidents like officer-involved shootings attract a significant amount of public and media attention. This is for obvious and valid reasons, and many of the recent strains on police-community relations relate to these uses of law enforcement power, their legitimacy, and the effectiveness of accountability measures for involved officers. In keeping with this reality, APD – and our Reports about the Department – seek to give these incidents special consideration.

Such events, however, are rare, and represent only a tiny percentage of the encounters that APD has in a given year, or the performance issues or challenges that it must deal with. Complaints from aggrieved members of the public about relatively minor allegations, and issues of possible employee misconduct that the public isn't even aware of, generate less scrutiny for obvious reasons. But these "everyday" or confidential interventions have a significance of their own. The legitimacy of the Department's process for investigating misconduct and addressing it is essential to internal confidence and operational health; in turn, these factors influence APD's outside reputation and public trust.

For purposes of this audit, we surveyed approximately 40 completed Internal Affairs investigations completed in 2017 and early 2018.[29] Some were quite grave, involving excessive force allegations that resulted in termination for involved officers, or even conduct that was potentially criminal and that led to the wider review of a special unit within APD. We cover some of these investigations in detail below, both for their intrinsic significance but also for the broader accountability and systems issues we noted within them.

At the other end of the spectrum were low-level discourtesy allegations by residents dissatisfied with their experience of the police. These conflicts are

[29] This was approximately one quarter of the total number of cases opened by APD during the audit period.

inherently less grave – but they certainly mattered to the people who raised them in formal complaints. And, in some ways, they are also reflective of the average resident's only encounters with the police, and the lasting perceptions that can emerge for better or worse. For these cases, our goal is to ensure that the Department has treated them with appropriate levels of objectivity and thoroughness.

As in the past, we noted strengths and occasional shortcomings in the Department's discipline process. Without weighing in regarding individual outcomes, we offer the related recommendations in the hope of enhancing future effectiveness in this important arena.

Excessive Force: Discovering a Pattern of Misconduct

One group of IA cases we reviewed for this report was distinct for its origin, scope, and outcomes. A 2017 pursuit of a stolen vehicle ended in a use of force involving several officers that initially appeared unexceptional in many ways. After a lengthy vehicle pursuit, the subject pulled into a driveway and, according to involved officers, attempted to flee. The officers reported that they used force as they struggled to control the subject, including the application of a carotid restraint. The subject, an active parolee, was not seriously injured, and the APD began its routine response. The on-duty lieutenant was notified of the incident and a sergeant was assigned to complete a Pursuit Critique as well as a report within the Force Analysis System (FAS).

When the FAS report was completed, nearly six weeks later, including a review of the officers' written statements and body worn camera footage, the sergeant and lieutenant agreed that the incident warranted further review by Internal Affairs. Other lieutenants with whom they consulted agreed. The concerns related to the way in which officers rushed to apprehend the subject, who the video showed lying on the ground with his hands in the air rather than fleeing, as well as the necessity of a strike to the subject's head after he was handcuffed.

The incident did lead to an administrative investigation and ultimately was referred to the District Attorney's office for consideration of potential criminal charges against involved officers. Officers were placed on administrative leave during the pendency of these investigations. Though the District Attorney eventually declined to file charges, the Department by then already had moved

proactively to perform an audit of one of the involved officer's body worn camera footage. This audit led to the initiation of four additional IA investigations into other incidents involving unnecessary force and undocumented detentions. In the end, the Department disciplined six officers: two had their employment with APD terminated, two others served significant suspensions, and two received written reprimands.

The incident resulted in a sixth administrative investigation, which the Department assigned to an outside, independent investigator because its subject was an APD command staff member alleged to have neglected his duties by delaying the referral of the original force incident to IA. In opening this investigation, the then-Chief's concern was that the supervisor had shown an inclination to view the incident as a training issue relating to tactical errors rather than a potential criminal matter that, at a minimum, should expose officers to the possibility of substantial discipline.

The outside investigator completed his investigation and, in the end, concluded there was sufficient evidence to sustain a charge that the supervisor had violated Department policy by not immediately directing an IA review. Two lieutenants had recommended at the completion of the FAS report that the incident be forwarded to IA to investigate, but the Captain waited to discuss the matter with others. Though only five days elapsed between presentation of the FAS to the Captain and his initiation of the IA investigation, one of the force incidents identified in the officer's body worn camera audit occurred during this interval.

Ultimately, because of the subject's rank, the City Manager's office became responsible for deciding the appropriate disposition in this case, and concluded it was an issue that should be addressed with the supervisor during a performance review rather than through the disciplinary system.

This case pointed to some weaknesses in the FAS reporting system and the process for initiating IA investigations. Part of the concern fueling the City Manager's office's disciplinary decision was the fact that the supervisor's delay was only several days, following a nearly six week interval between the incident and completion of the FAS report. There were several factors cited – vacations, medical leave, a training conference – but those involved also noted there was no requirement for when a FAS must be completed (as opposed to the Pursuit Critique, which did have a deadline, which the sergeant met).

This has been remedied, with new parameters set requiring sergeants to complete FAS reports within seven days of an incident. There also is a new process for review of completed FAS reports, with all being routed to the FAS coordinator as well as the assigned lieutenant (and ultimately, captain) to ensure consistency. The FAS coordinator, who is not the direct supervisor of the officers involved in the use of force, can now recommend that an IA investigation be initiated through his or her own chain of command, so that decision is no longer solely up to the officers' supervisors.

Regardless of specific deadlines and protocols for review, or whether they are met, the initiation of an IA investigation following a use of force incident does not hang on the formality of completing a FAS report. The sergeant responsible for reviewing this incident could have identified very quickly concerns about the use of force after reading the officers' reports and watching their body-worn camera footage. Promptly raising those concerns with superiors rather than waiting for the official report to be completed would have resulted in a more timely Department response.

That the sergeant here did not do so is not a failure of process but a question of calibration. Once Department executives watched the video of this incident, they were immediately concerned and moved to place the officers on administrative leave and refer the matter to the District Attorney's office. This represents a particular orientation, with a recognition that the use of force sometimes rises to the level of misconduct. The Department's leaders should be able to expect their sergeants and lieutenants to share this view and act accordingly when reviewing the actions of those they supervise. To identify those that do is the challenge of the promotional process. We have discussed this issue with Department leaders, and offered some suggestions for ways to identify those within the agency most likely to meet their expectations as supervisors.

Among the lessons learned from this incident, it is important not to lose sight of the proactive approach to addressing concerns about the original force incident, for which the Department should be commended. After viewing the two primary officers' body worn camera footage and recognizing the failure to accurately report the force they used, Department leaders grew concerned – rightly, it turned out – about other activity these officers might not have reported. They initiated an audit of the video recordings from these officers' body warn cameras, a time-intensive task to which they devoted a sergeant full time, reassigning him from his regular duties. The audit led to additional misconduct allegations and bolstered

the Department's decision to terminate the employment of these officers. The resolve of Department leaders to commit such significant resources was extraordinary and serves as a model for using body worn camera footage to further the goal of officer accountability.

Systemic Shortcomings: Confidential Informants, Misconduct, and Accountability

One case we looked at concerned alleged misconduct that dated back to 2014 and included a criminal review of the involved investigator's actions. The officer was accused of improperly tipping off his own confidential informants to protect them from exposure to other law enforcement agencies. Taking advantage of access to "de-confliction databases" shared by law enforcement to avoid miscommunication or inadvertent interference, the investigator would learn when his informants were suspects and alert them accordingly. The purpose was to maintain their viability for the investigator's own operations.

A federal agency raised concerns about the investigator's conduct, and the criminal and internal investigations followed. After the District Attorney ultimately rejected the case, the Department's investigation culminated in a finding of wrongdoing and a lengthy suspension – which was itself later overturned almost in its entirety.

The process dragged on for years, and at best featured confusion and inefficiency that reflected poorly on the Department. The Internal Affairs investigation was itself reasonably effective in sorting through a highly arcane series of allegations and explanations. (Some of the original charges against the investigator were established to be unfounded.) However, the documents in the case file tell the story of a disordered chronology and a significant difference in viewpoints between high-ranking APD executives when it came to evaluating the case.

In the end, the significantly reduced suspension was justified in a memorandum that raised concerns of its own. Essentially, the argument was that the investigator had been acting with the knowledge of (now-retired) supervisors, and that the entire unit's tense and competitive relationships with other local and federal law agencies created a unique context that explained some of the subject officer's decision-making and actions. This helped mitigate the sense that the officer had "gone rogue." But it was itself disconcerting as to the practices of the unit as a

whole – particularly with regard to its dealings in the notoriously problematic realm of interactions with confidential informants.

The case and its protracted, convoluted aftermath did little to inspire confidence in the workings of the unit or the APD disciplinary review process. To the Department's credit, though, it did lead to a systemic re-evaluation of the unit and its functions. The unit's operations were suspended pending a full-scale audit, and only recently resumed. This positive step offers an example of an important, and often overlooked, dimension of misconduct investigations: the identification of systemic concerns that merit intervention on a going-forward basis.

> RECOMMENDATION 29: The Department should streamline and otherwise clarify the tracking process for the various stages of appeal and reconsideration that follow the imposition of discipline, so as to reduce confusion and promote consistency and legitimacy of outcomes.

Other Investigative Issues: Repeat or Extreme Complainants

The presence of a small number of "high-volume" or especially persistent complainants is an issue that many if not most law enforcement agencies must address in their engagement with the public. Circumstances vary, of course, but these situations and complaints also have some common elements: a deep distrust of the police and/or the justice system as a whole, resistance toward unfavorable evidence or outcomes, allegations that expand or shift over time, and a tendency toward repetition and fixation. The involved individuals are often quite sincere in their beliefs about mistreatment, and the complaints are often grounded – at least in part – by the facts of an actual negative encounter.

Over time, interactions with these members of the public can become challenging for law enforcement. Even sustained findings of officer misconduct or corroboration of claims may not suffice for the complainant, if the consequence or corrective action is not deemed adequate. And when allegations are disproved, the objective evidence is often discounted in frustrating ways. In short, the required dedication of resources in the service of those who are *least* likely to be satisfied makes for an unfortunate combination.

We are sympathetic to this dynamic. However, in our experience, it is important for agencies not to yield to any temptations toward giving short shrift to the review

of relevant incidents. On the contrary, the best and most progressive approach is to ensure that investigations that involve demanding complainants are as thorough and objective as possible.

Such diligence is always best practice, of course. But in these cases, it has three additional benefits. The first is to stand well-prepared for the skepticism and inevitable challenges with which the complainant may respond. The second is to reinforce the legitimacy of the agency's internal review systems in the view of objective third-party observers – whether it be a formal oversight body or curious members of the public at large. And the third is the opportunity that careful scrutiny – even of biased and adversarial feedback – might somehow offer for enhancing the effectiveness of individual officer performance or broader agency operations.

A few of the cases we assessed during this period came from complainants who fit the profile of being repeat, demanding or unreasonable "customers" of the process. While the handling investigators showed patience and professionalism in their dealings with these individuals themselves, there were instances when the underlying allegations were addressed more effectively than in others.

A creditable response occurred in the case of complainant who alleged that the police responded improperly to her reports of being a victim of microwave-based torture. Though the underlying assertions were obviously unlikely on their face (and had been made in the past), the Department took the occasion to assess the way that the police contacts were handled. They found calls to dispatch and a report that had been taken – all signs of appropriate objectivity and effort.

Another case involving a frequent complaint was, however, dismissed somewhat peremptorily. An Internal Affairs sergeant attempted to interview the complainant by phone to clarify and refine his written complaint – which named specific officers and a particular encounter but lacked clear allegations. The resulting interview was not especially productive. The tone was largely cordial, but it featured several lengthy asides from the complainant that were difficult to follow or to connect to the core issues. Even descriptions of the relevant conflicts were themselves unfocused and lacking in factual detail.

The investigator was creditably courteous and patient throughout the interview. But, less effectively, he also did little to help shape it in directions that might have

established the issues with more particularity and provided some concrete investigative leads.

Instead, the Department seemed content to characterize the complaint as "nonsensical," and to limit its workup and analysis accordingly. The criminal case was alluded to but not accompanied by clarifying paperwork. None of the named officers was interviewed, and the allegations were deemed "Unfounded."

The challenging nature of interactions with the complainant is evident in this case file, from the original written document to the phone interview to the sometimes contentious and accusatory messages that he subsequently left. Some measure of frustration would be understandable. At the same time, we would respectfully encourage the Department to respond by moving in the *opposite* direction: by "leaning in" to the customer service and the creation of a thorough, convincing case file.

> RECOMMENDATION 30: APD should emphasize the importance of objective fact-gathering and effective documentation, even (or especially) in the context of persistent or intractable complainants.

Body Camera Issues

For several of the cases we reviewed, the Department's ability to make effective determinations about what had occurred was compromised by the involved officers' failure to engage body-cameras as required by policy. This is inherently disappointing, since one of the very purposes of the cameras is to reduce the number of factually disputed encounters between police and public.

When the underlying allegations relate to discourtesy, for example, as in one case when a man resented his treatment as he approached an officer at an accident scene, a somewhat inconclusive "not sustained" is rendered particularly unsatisfying by a lack of recorded evidence. (Months later, the officer was also found to have violated the body camera policy in another case.)

Similarly, when racial profiling is alleged, the sensitivities and nuances of those interactions make the objectivity of a camera recording particularly useful. But in a complaint case where an African-American woman disputed the legitimacy of a traffic stop and cited several particular comments that troubled her, no recording

existed to corroborate or refute her claims. [30] This led to another "not-sustained" finding.

These lapses are unfortunate, especially since the Department has now had the cameras for some four years. And, to its credit, the Department often investigates and reaches findings when policy violations occur. What is less impressive, though, is the leniency with which Department management responds in terms of consequence. The default "discipline" seems to be an oral reprimand or performance log entry – two approaches that have their place but that, in our view, are often inadequate as sanctions for body-camera related infractions. This is especially true in the case of officers who are repeat offenders – as was the subject of the racial profiling complaint cited above.

Our support of a more severe sanction is not for the purpose of "punishing" officers or being gratuitously heavy-handed. Instead, it is to send a message commensurate with the seriousness of the violation, and thereby to correct behavior and maintain the standards that supposedly matter. While we acknowledge that problems with the body cameras are often mechanical or otherwise innocent oversights (as opposed to malicious attempts to conceal bad behavior), missing recordings create inherent deficiencies in the evidence and should be treated as performance issues that warrant formal intervention. After some four years of the Department's transition to this equipment in patrol, the officers are presumably "used to" the cameras – and the attendant requirements for using them – by now. The initial grace period for mistakes has presumably passed. Accordingly, disciplinary responses to these issues are clearly appropriate.

> RECOMMENDATION 31: The Department should increase the level of its disciplinary sanctions for violations of the body-worn camera recording policy, particularly with regard to repeat offenses.

[30] Contrast this with another case in which a Hispanic complainant alleged racial bias during a car stop in which the officer also supposedly damaged property in his vehicle. One of the complainant's contentions was that the officer asked him repeatedly – and presumably antagonistically – if he spoke English. But a body camera recording captured the entire encounter. It showed the officer maintaining a polite demeanor and refuted the "Do you speak English?" charge.

Interviews of Complainants

Several of the complaint cases that we reviewed featured a follow-up interview in which an assigned investigator reached out to the complainant to gain further information about allegations. This is standard and appropriate practice, and at times the investigators showed admirable diligence in attempting to locate and arrange a time to speak with the relevant parties.

However, we also noted two potential concerns in this arena. The first was the Department's reliance on telephonic rather than in-person interviews. Although this practice may be more convenient – and may at times be the only available option based on the *complainant's* preference – there are ways that an in-person interview is clearly preferable. Not only does it lend itself to a more comprehensive interaction, but it also sends a message of commitment and seriousness that has intrinsic value. The value of in-person interviews is particularly relevant in allegations of inappropriate force as the complainant can use gestures and positioning to better explain his/her account. This combination of investigative utility and better "customer service" is one the Department should bear in mind as it allocates time and resources to these complaint investigations.

> RECOMMENDATION 32: The Department should develop a policy that presumes that complainant interviews will be "in-person" and requires investigators to document the circumstances in which an in-person interview is impracticable.

The second issue we note here was a handful of instances in which the *subject* of the complaint was interviewed *prior to* the full interview of the complainant him- or herself. Instead of using the more fully developed complaint to frame the issues, the questioning was based on the complainant's initial outreach to the Department, along with other available evidence. While the difference isn't necessarily or always significant, the proper framing of all relevant issues is more likely to occur if the complainant is interviewed first.[31]

[31] For example, in the "racial profiling/damaged property" complaint mentioned above, the investigator's interview led to the man's expressing an additional concern about the perceived aggression with which the officer first approached the vehicle. This detail – not captured in the original outreach to the Department, or reflected in the body camera footage, was worth exploring.

RECOMMENDATION 33: The Department should prioritize the full interview of complainants by investigators prior to the subject interview of the involved personnel.

Racial Profiling Cases

Apart from the disputed incidents mentioned above, racial profiling or discrimination was a feature in several other complaint cases we reviewed. (Because of universal public concern about these types of allegations, we specifically ask for those as part of the range of cases we evaluate each year.) A total of 19 separate complaints contained some element of racial grievance. None resulted in sustained allegations. These numbers reflect a couple of realities – the extent to which racial distrust underscores contemporary police-community relations, and the difficulties of proving improper bias in the absence of overt evidence or admissions by involved personnel.

Examples included the following:

- An Hispanic man asserted that officers had improperly taken the side of the other parties in a parking lot dispute because of their status as white and economically privileged.
- An African-American man claimed that he should not have been the focus of an investigation in which he collided with an older Asian driver as he rode on his scooter, and that the police would have reacted differently if he had been white.
- An African-American man who received a citation for tinted windows claimed he was stopped improperly because of his race, and then ticketed in retaliation for asking for the officer's badge number.[32]
- An Hispanic man claimed that the multiple officers who responded to a traffic stop were an overreaction predicated on his race.

The Department is conscientious about flagging and pursuing these allegations when they arise – even if they are just one component of a complaint that has another focus. This is to their credit. And we did not see instances in which we

[32] Interestingly, the officer's body camera recording provided some support for this latter theory. But this is an exercise of officer discretion that is not prohibited by policy, given that the infraction itself was legitimate and the decision was not race-based.

challenged the legitimacy of the findings or had reason to believe the officers were acting in bad faith.

That said, we do see potential benefit in the Department refining and standardizing its approach to addressing these allegations. For example, in some of the cases, the prior training that involved officers had received about bias and tolerance was cited as if it helped disprove the allegation. (One reference dated back to a 2003 program.) This is noteworthy for two reasons. First, it is of course possible for officers to have experienced relevant training and still act in improper ways. Second, the absence of the same analysis in other cases reflects the lack of a focused, systematic plan for assessing the facts and circumstances when these allegations arise. If the training is worth mentioning (and perhaps it is – we certainly advocate *attendance* at programs to heighten officer sensitivity to racial dynamics), then it might be useful to do so as a standard practice. (This would also mean that the absence of such training might be potentially worth mentioning or remedying as well.)

Another investigator took the initiative to pull three months' worth of citation records to check for patterns of potential bias. (None emerged.) This is an interesting idea, and one we have seen emulated in some form in other agencies. Again, though, it was not routinely done across similar cases we reviewed. And there are other data points – such as total number of traffic *stops* by race – that could provide additional (or more) insight about individual officer practices.

In short, we encourage the Department to review its baseline approach to this important area of complaint investigation so as to promote consistent and productive assessments of individual officer performance and the broader dynamics they reflect.

In addition, because of the inherent difficulty in proving (or disproving) allegations of bias, several police agencies have effectively used mediation as an alternative approach to addressing the complainant's concerns. This type of resolution allows the complainant and officer, under the facilitation of a neutral mediator, to understand the perspective of each and can lead to a resolution consistent with contemporary principles of restorative justice. APD has not deployed mediation as a way to resolve complaints received, but should begin working to develop an alternative resolution program.

RECOMMENDATION 34: The Department should review its investigation protocols for allegations of racial bias or discrimination, and should seek out “best practices” for consistent, effective assessment of these matters.

RECOMMENDATION 35: The Department should create an alternative resolution system (such as mediation) for addressing certain complaints.

Use of Force

Beyond the most significant uses of force – shootings and other uses of force that result in death or serious injury – that are assessed through the Department's MIRT process, the most notable force cases from this reporting period were those that resulted in the IA investigations and serious discipline that we discussed in the section on Internal Affairs, above. The vast majority of force used by APD members, though, results in neither an IA case nor investigation by MIRT personnel. Most are relatively minor and involve neither serious injury nor complaint.

Nonetheless, the Department recognizes that each use of force represents an exercise of police power that deserves attention. It has accordingly developed protocols to ensure that even minor force incidents receive some level of formal scrutiny. We looked at the review packages (documentation, recorded evidence, and supervisory analysis) for 12 randomly selected incidents from 2018 in order to assess this process.

After any use of force, involved officers have an obligation under policy to report their actions, and their direct supervisors are responsible for conducting a formal review. The primary focus is on whether the force was justified by the circumstances and objectively reasonable in its application. This is an important determination. However, in recent years we have repeatedly encouraged the Department to enhance its approach in terms of scope, depth, and consistency. Our view has been that even "routine" uses of force merit attention not only to accountability but also to broader issues of performance, training, tactics, equipment, policy, or supervision.'

To its credit, APD has made recent strides in this regard. It now tracks force incidents in an improved "Force Analysis System" (or FAS) that utilizes shared data bases for more efficient and effective assessments. The Department has made notable improvements to FAS and its overall process for reviewing force since our

last report, including addressing one of our primary recommendations – that the Department should gather all evidence and documentation relevant to a particular force incident in a segregated and focused location.

Our vision was for APD to create a "force package" for each incident where officers would write a report detailing their use of force separately from their documentation of the underlying crime or complaint that brought them into contact with the subject of the force. The Department continues to push back against this type of separate report writing, but FAS does now collect under one file number all of the information having to do with each force incident. This includes a summary written by the supervising sergeant, detailing the force used by each involved officer, the investigation completed, and a conclusion about whether the force complied with applicable policy.

The Department also has introduced a number of changes to FAS that improve overall force documentation and review. One major improvement is the inclusion of involved officers' names in a searchable format. In the past, the Department was hesitant to categorize incidents by name because of concerns about officer's privacy and a reluctance to view force as a measure of officer performance, but that limited the usefulness of the database for supervisors. While the current search mechanism still may be less than ideal, the Department's ability to identify officers who may be using a disproportionate amount of force is an important evaluative tool. Identifying officers within the force database was the subject of a recommendation in our 2015 report, and we are pleased to see that the Department has recognized its importance.

In addition, there are now parameters within the database that require the full report to be completed within seven days of an incident, another important mark of progress that will help the Department identify potential problems or concerns about a particular incident a more timely way.

Perhaps most notably, all FAS reports are now routed to the FAS coordinator, a sergeant who works in the Professional Standards Division, who, along with his lieutenant, must approve of the findings made by the supervising field sergeant who reviewed the incident and prepared the report. The FAS coordinator is differently situated from the field sergeant, in that he is not the direct supervisor of the involved officers and he reviews all uses of force Department-wide. As a

result, he is in a better position to recognize force trends and may have a different perspective on a specific incident.[33]

Nonetheless, despite these improvements in force tracking and reporting, we found cases in which the review of incidents did not formally address important issues related to the use of force or the subsequent investigation. Instead the FAS reporting generally focused only on the force and officers' compliance with force policy. As we have said repeatedly – in these reports and in various meetings with Department leaders – a more ideal review process scrutinizes force incidents holistically, going beyond the question of whether a use of force was justified and looking at broader issues including conformance with training and principles of sound tactical decision-making, as well as questioning any issues or concerns surrounding the investigation.

In order to facilitate more holistic review of non-critical force incidents, FAS should be expanded to include questions beyond just whether the force was consistent with Department policy. Currently, sergeants prepare a narrative of the incident, incorporating information from officers' written reports and providing a conclusion about whether the force was consistent with APD policy. Ideally, however, reports should go well beyond that baseline conclusion, and supervisors charged with reviewing the incident should address a number of questions before concluding the force was within policy. These include questions such as:

- What was the physical or mental condition of the person against whom force was used?
- Was there a reasonable opportunity to safely de-escalate the incident in order to lessen the likelihood of the need to use force or to reduce the level of force necessary? If so, did the officer using force attempt to do so? If not, what was the reason?
- Was there a reasonable opportunity to safely use a weapon, device, or force technique that might lessen the force needed to overcome the threat posed? If so, did the officer attempt to do so? If not, what was the reason?
- Once the use of force began, was it reasonably decreased or stopped as the level of resistance/threat/harm decreased or stopped?

[33] Below, we discuss the larger data analysis potential of the system.

- Did involved and witness officers notify a supervisor of the force incident in a timely way?
- Did involved and witness officers promptly write reports that thoroughly answered all relevant questions about the incident?
- Were the officers' written reports consistent with body-worn camera footage?
- Was the person against whom force was used provided prompt medical assessment and care?
- Were the injuries noted and/or documented by medical providers consistent with the level of force reported?

Prompting supervisors tasked with reviewing force at all levels to answer questions such as these questions would allow the Department to scrutinize incidents more thoroughly, with an eye toward maintaining accountability while also identifying opportunities for Department-wide improvement.

Interestingly, at least one of the cases we assessed reflected the potential for broader and deeper review. It involved a use of force inside the Department's jail, in which the attempt to move a young, drug-impaired arrestee from his cell led to a significant physical struggle. The force was ultimately deemed in policy. However, the supervisor in charge of the review also noted "several opportunities for future encounters that can be learned from this incident," and detailed some of the alternative approaches to handcuffing and extracting the subject that may have worked better. The review also addressed the failure of several involved officers to engage their body cameras.

From our perspective, this seemed like thoughtful and constructive analysis that turned the incident into a learning opportunity. While not every case lends itself to this sort of insight, this example is one the Department should look to emulate where applicable.

> RECOMMENDATION 36: APD should require supervisors to evaluate all the circumstances surrounding a use of force before reaching a conclusion about whether the force was consistent with APD policy, and should pursue and document any related insights or lessons learned from the broader event.

Addressing Communications and Tactical Issues

Some incidents we reviewed raised questions about officers' tactical communication with subjects and witnesses.

- While confronting a domestic violence subject just inside his house, with multiple family members present, an officer ordered, "show me your f***ing hands or I'll f***ing shoot you." After a second officer came in and calmed things down with effective communication, the subject willingly went outside with officers.

- In that same incident, the subject ended up attempting to flee back into his home, and an officer Tased him, an effective and appropriate use of force, given that the officers had information the subject might have a weapon in the house. However, when talking to the family member witnesses as the subject was being taken into custody, that same officer was very disrespectful, saying things like, "shut up" and, "stop crying," and then gratuitously adding to the restrained subject, "you wanted to make things complicated, dude," and "stop whining."

- In a case involving the theft of some beer, one young subject attempted to flee as officers detained him and two friends; he was taken down and subdued with elbow strikes. Asked why he ran, the subject said he was "scared," only to have the officer reply, "Horseshit."

- Officers confronted a subject sleeping in a resident's backyard. They woke him and almost immediately went hands-on, without seeming to give him time to comply with their commands. A fairly significant struggle to take him into custody followed. While this tactic of moving in quickly was understandable on some levels, it was worth discussing whether using calm communication and maintaining some distance from the just-awakened subject might have been more effective.

- While later interviewing the subject in the hospital, one of the involved officers argued with the subject in response to the questions he asked, at several points saying, "that's bullshit." And "when an officer tells you to stop, you stop." And if you had followed directions, "you would not be in the hospital right now."

In at least some of these cases, there may have been informal efforts to address these issues – a briefing or counseling by a sergeant, for example – but no documentation of those efforts. Aside from the fact that this leaves subsequent reviewers (both within and outside the Department) wondering whether these important issues were even identified, it likely also cuts off the possibility of any formal remediation that might be appropriate. For example, recognizing that some of these incidents could have been handled more effectively, they represent possible training scenarios or a need to re-evaluate policy.

Of course, there are many instances where APD officers resolve situations through effective communication and de-escalation efforts. Those generally are not captured in ways that would become the subject of an audit, and may not even result in an arrest or other report. But even among the cases we reviewed that ultimately ended with force, we noted instances of positive efforts to manage situations through calm and respectful interaction:

- Responding to a call regarding a possibly suicidal subject, officers responded and engaged the individual in conversation about the reasons for his despondence. The lead officer, in particular, was very skillful and empathetic in addressing the individual, who was reported to be developmentally disabled and mentally ill. While officers eventually had to take him down and restrain him as he attempted to run away from them into traffic, they got him in handcuffs and continued to talk to him in a calm, thoughtful way until paramedics arrived. The lead officer also engaged with the individual's caregiver and made efforts to contact his parents.

- In the aftermath of an arrest involving a minor use of force, officers showed patience and professionalism in their dealings with a DUI suspect who was verbally aggressive and belligerent as he waited on a bench in the station jail. As the review summarized, "Officers were professional, tolerant, and patient."

A more thorough review process will consistently recognize this type of commendable performance, providing a mechanism to affirm individual officers as well as provide positive reinforcement of Department training efforts.

Investigative Issues

Officers' report writing on use of force remains generally good, with sufficiently detailed descriptions of the force used and effective articulation of their justification. However, there is one persistent problem affecting the quality of investigations into these force incidents – the continued inconsistency of interviews of individuals on whom force was used. Recommendation Six from our 2015 report addressed this issue: *APD should modify its force investigation protocols to require a supervisor who was not involved in the force incident to interview the person upon whom force was used.*

Unfortunately, in the cases we reviewed for this report, we continued to see subjects being interviewed by non-supervisors and, even worse, by officers who were themselves involved in the force incident. One case cited above provides a clear example of why this is generally a bad practice: The officer asked several questions but because he was emotionally invested in the incident, was unable to dispassionately listen to and record the subject's answer. Instead, he repeatedly interjected his own viewpoint. The subject was attempting to give the officer his perspective, but the officer continued to argue with him, telling him his view was "bullshit." It was among the most biased and ineffective "interviews" we have seen. There is no documented effort to address this by the supervisor responsible for reviewing this incident.

The same phenomenon undermined another recorded communication that occurred at the hospital with an obviously impaired subject. Among the leading questions were the following: "Do you want to apologize?" and "Are you sorry for having fought with the officers at the station?" Apart from the dubious value of the Miranda advisement that preceded the questioning (given the subject's limited capacity for a valid consent), this approach veers from objective fact-gathering in ways that undermine the legitimacy of the process.

Accordingly, we reiterate our prior recommendation on this point, with an additional point about supervisor accountability.

RECOMMENDATION 37: APD should ensure its force investigation protocols require a supervisor who was not involved in the force incident to interview the person upon whom force was used. Lieutenants reviewing force incidents should ensure that involved officers have not conducted subject interviews.

Two other investigative issues arose in our review of cases:

- In some cases, officers continue to record via their body-worn cameras while they are interviewing subjects and witnesses. In other cases, we received no video footage of these interactions.

  The Department's policy on activation of body-worn cameras seemingly requires these interactions to be recorded, but the inconsistency with which they are suggests a need for clarification.

  RECOMMENDATION 38: APD should issue a training bulletin reminding officers of the body-worn camera activation requirement for interviews and other interactions with subjects and witnesses following a use of force incident.

- In one case, there was a reported problem with the way the Taser evidence synced up, which seemed to be recognized by the sergeant as an ongoing problem. But there was no documentation to suggest that anyone was doing anything to address it.

  We are hopeful that these types of issues, while tangential to the actual use of force, will be addressed in the course of a more thorough force review process.

Use of Force Data

Last year, APD officers reported a total of 157 force incidents[34] occurring during 199,305 incidents involving contact with members of the public. Of these, only six resulted in major injury or death and were reviewed in the Department's MIRT process.

In the remaining 151 incidents, close to half (43%) of the force used[35] was "physical control" of the subject, meaning the officers did not use any weapons or strikes but often took the subject to the ground in order to handcuff him or her. Twenty-nine percent of force used involved application of a hobble device, either as a restraint or as a preventative measure. Body strikes (punches) and electronic control devices (Tasers) each accounted for about 5% of total force used, and control holds using a baton or other weapon accounted for 4% of force. A carotid restraint was applied in 2% of the total. Other types of force (K9 bites, impact weapons, and display of firearm, for example) accounted for less than 2% of all force used.

Using the FAS database, the Department was able to quickly provide these total numbers of types of force used, with a high degree of confidence in their accuracy. Drilling down further into the numbers, to include the demographics (race, ethnicity, sex) of those on whom a particular type of force was used proved somewhat more difficult as a logistical matter. The Department keeps the data, but has to request its database vendor to prepare a report to capture such breakdowns. Likewise with our request to categorize force based on a subject's mental health status, or the impact of drugs or alcohol.

It is also worthwhile to note the things that are not counted – such as successful de-escalation efforts, or the number of times officers might have been justified in

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[34] Force incidents are reported in FAS if they meet one or more of the criteria for reportable force:

- The force resulted in visible or physical injury;
- The individual complained of pain resulting from the force;
- Application of a carotid restraint or a control device, such as Taser, chemical spray, baton, or restraint device;
- The individual was rendered unconscious.

[35] Because there often are multiple officers and different modalities of force involved in a single incident, the total number of uses of force is greater than the number of force incidents – 498 recorded uses of force in the 151 incidents. For example, an officer may use a body strike, and then a Taser before controlling a subject and applying a hobble restraint. That would account for three uses of force in a single incident.

using force but instead found another way to gain the subject's compliance. This is difficult data to capture, but the Department should nonetheless consider ways to identify and record these incidents, both to commend the individual officers involved and to send a broader message to Department members as well as the public about the value APD places on the sometimes intangible skill it takes to effectively communicate and de-escalate.

The value of this data goes beyond the Department's internal functioning, and should be used to promote a culture of transparency. Regularly publishing data on law enforcement activities – including stops, summonses, arrests, reported crime, and use of force – would provide the public a window into Department functions and build public trust for the agency, consistent with the call for transparency by President Obama's 2016 Task Force on 21st Century Policing.

> RECOMMENDATION 39: APD should regularly publish on its website its use of force data, broken down by types of force used, and demographics, and should include data on the extent to which alcohol, drugs, or the subject's mental health status played a role in the incident.

Recommendations

1 APD should develop and enforce internal guidelines and expectations for when an administrative review of a major incident is to be formally completed.

2 The Department should standardize the practice of conducting separate administrative interviews of involved officers, witness officers, and on-scene supervisors in a shooting, to ensure that all potential performance and policy issues are properly addressed.

3 The Department should prioritize the obtaining of an interview statement before the end of the relevant shift from officers who are involved in a shooting; if they are unwilling to provide a voluntary interview, they should be ordered to submit to an administrative one.

4 The Department should implement an investigative protocol that restricts the viewing of body-worn camera recordings by officer involved in a critical incident until after they have given an initial statement about their actions and perceptions.

5 APD should strive to achieve with more consistency the identification and remediation of tactical decision-making issues that the MIRT process accomplishes at its best.

6 The Department should make the assessment of bullet strikes – and their implications for backdrop and other tactical considerations – a routine part of its shooting review process.

7 APD should brief the involved officer about the shortcomings of the so-called “21-foot rule” and issue a training bulletin instructing its officers on the principles to be applied when confronting a subject armed with a knife.

8 The Department's administrative interviews after critical incidents should address key factual issues as thoroughly as possible, including any gaps or discrepancies between recorded evidence and officer recollection.

9 Administrative investigations should pursue all relevant policy issues in connection with a critical incident and should reach formal conclusions, even if extenuating circumstances make responsive discipline less necessary or appropriate.

10 APD should reconvene its MIRT review upon receipt of the District Attorney's investigative report to identify any additional issues and re-evaluate any reforms coming out of its initial review.

11 APD's review should identify and address body-worn camera footage that reveals inappropriate and/or unprofessional remarks made by its officers.

12 When APD finds inaccurate information in the District Attorney's investigative materials, it should advise the District Attorney's Office so that any inaccuracies can be corrected.

13 The Department should assess whether its new foot pursuit policy is meeting its goals of promoting increased tactical soundness and officer safety by reviewing and monitoring future pursuits, including officers' reasons for pursuing and supervisors' response to those incidents.

14 APD should develop a supplemental review process to ensure that issues identified during the investigation and MIRT review are appropriately addressed.

15 The Department should identify and remedy any radio communications issues that arise during its review of tactical operations.

16 APD should create written protocols to ensure that the complete criminal investigative file of the officer-involved shooting investigation is obtained and included in its administrative materials.

17 The Department should revisit its protocols and training regarding the best approaches to communicating with family members of the subject in a critical incident scenario, and should appropriately investigate complaints that arise from these situations. Included in this review should be whether APD should assign personnel unaffiliated with the investigation to serve as a liaison for the family of individuals seriously injured or deceased as a result of police actions.

18 The Department should formally review the most recent five years' worth of carotid control hold incidents to determine whether its inherent dangers continued to be outweighed by the overall effectiveness of the technique, and to explore the advisability of ending authorization of the hold, or at least only allow it when deadly force is authorized.

19 The Department's analysis of off-duty force and/or arrest encounters should reflect an emphasis on the special challenges of such actions, and individual incidents should prompt training bulletins and reminders as needed.

20 When an incident becomes the subject of a MIRT review for whatever reason, the Department should ensure that it maintains its usual commitment to holistic review and investigation, and responsive action items and remediation.

21 The Department should consider more effective ways to respond to officer language and demeanor issues when they emerge in the context of the review process.

22 The Department should utilize its MIRT protocol in a wide range of situations, and continue its efforts to educate all personnel about its purpose and potential benefits.

23 The Department should give administrative attention to the mechanics of closure for MIRT action items, to help ensure that the intended review and outcomes are occurring.

24 The Department should continue the training and evaluation efforts that arose from its most recent study of vehicle pursuits, and should remain open to revisions of policy as needed in light of individual incident review (and per the study's recommendation).

25 The Department should amend its MIRT policy to formalize a commitment to using the review process to analyze high profile and multi-faceted incidents, including those that raise outside concerns about the Department's handling of the incident.

26 The Department should pursue training opportunities to address the unique issues that arise when dealing with off-duty law enforcement personnel in the context of potential criminal conduct.

27 APD should reinforce the critical importance in ensuring that information publicly communicated about an event be entirely accurate.

28 When publicly disseminated information about a police involved event proves misleading or inaccurate, APD should move promptly and readily to correct any confusion.

29 The Department should streamline and otherwise clarify the tracking process for the various stages of appeal and reconsideration that follow the imposition of discipline, so as to reduce confusion and promote consistency and legitimacy of outcomes.

30 APD should emphasize the importance of objective fact-gathering and effective documentation, even (or especially) in the context of persistent or intractable complainants.

31 The Department should increase the level of its disciplinary sanctions for violations of the body-worn camera recording policy, particularly with regard to repeat offenses.

32 The Department should develop a policy that presumes that complainant interviews will be "in-person" and requires investigators to document the circumstances in which an in-person interview is impracticable.

33 The Department should prioritize the full interview of complainants by investigators prior to the subject interview of the involved personnel.

34 The Department should review its investigation protocols for allegations of racial bias or discrimination, and should seek out "best practices" for consistent, effective assessment of these matters.

35 The Department should create an alternative resolution system (such as mediation) for addressing certain complaints.

36 APD should require supervisors to evaluate all the circumstances surrounding a use of force before reaching a conclusion about whether the force was consistent with APD policy, and should pursue and document any related insights or lessons learned from the broader event.

37 APD should ensure its force investigation protocols require a supervisor who was not involved in the force incident to interview the person upon whom force was used. Lieutenants reviewing force incidents should ensure that involved officers have not conducted subject interviews.

38 APD should issue a training bulletin reminding officers of the body-worn camera activation requirement for interviews and other interactions with subjects and witnesses following a use of force incident.

39 APD should regularly publish on its website its use of force data, broken down by types of force used, and demographics, and should include data on the extent to which alcohol, drugs, or the subject's mental health status played a role in the incident.