Portland Police Bureau

2016 Q2 Force Audit Report

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Strategic Services Division

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Force Audit Report

Q2 2016 (April – June)

Introduction

This audit was created to satisfy the Department of Justice's requirement for presentation and analysis of the data captured on officers' uses of force. This audit is also intended to be used to identify patterns and trends to inform the Chief, the PPB Training Division and the Training Advisory Council in order to propose changes when necessary to policy and training.

The auditing process is triggered when an After Action Report (AAR) is sent to the Force Inspector's analysts. Instances where an AAR is not forwarded for audit are caught after the end of the quarter when data is pulled from the Force Data Collection Report (FDCR) database and cross-referenced with AARs that have been received and audited. The analysts then review all reports, photos, videos, and supplemental information to audit for consistency and to ensure all reporting requirements outlined in the DOJ Settlement Agreement are met. These audits are then used to answer paragraphs 74, 75, 76, and 77 of the DOJ Settlement Agreement.

Recommendations

- The development of a report writing Directive for officers, detailing Portland Police Bureau's (PPB's) current expectations of reporting content for officers.
- The revision of Directive 940.00 to include additional clarity around 940.3.4.2.1.
- The revision of Directive 1010.00 to include clear definitions for all force options with particular attention given to the takedown force option.
- The development of supervisor-level training around the review of officer reports. This training should clarify reporting items that require corrective action and documentation of that action in EIS.
- The development of officer-level training around the correct completion of the FDCR and narrative reports, including detailed direction for documenting suspect injury, other force options considered, and the role that mental health issues had in the officer's force decision making process. All PPB officers, including those at the Specialty Divisions, should attend this training.
- Additional officer-level training around requesting and waiting for a cover officer to arrive.

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Force and Subject Resistance

Overview

One hundred forty cases were audited during Q2 (April - June) 2016. Of the 140 After Action Reports (AAR) audited there were 11 complaint of injury (COI) cases, in which no FDCR (Force Data Collection Report)-level force was used. The 140 cases contained 215 officer-subject interactions.[1] One hundred ninety-five officers utilized 230 FDCR-level applications of force. This resulted in 1.8 force applications per force case and 1.2 force applications utilized per officer.

Summary of Audited Cases

140 Cases Audited	**129 FDCR-Level Cases Audited**
	11 Complaint of Injury Cases Audited
215 Officer-Subject Interactions	**195 FDCRs (FDCR-Level Officer-Subject Interactions**
	20 Complaint of Injury Officer-Subject Interactions
	230 Applications of FDCR-Level Force

Summary of Force Options Applied

Force Options	Total Applications
Baton	1
Control Holds w/Injury	9
K9 Bite	5
Less Lethal Bean Bag	2
Pepper Spray	4
PFA	17
Strikes/Kicks	25
Takedown	146
ECW	21
Total	230

PFA: Pointing of a Firearm. This force option was audited only when used with another AAR generating force option (takedown, for example). Cases involving PFA only do not generate an AAR. This number is not representative of the total number of PFA applications.

Force Applications and Officer Precinct/Division

Patrol precincts used more force applications than the other precincts/divisions of the Portland Police Bureau (PPB). East Precinct used the greatest number of force applications (92 applications), followed by Central Precinct (67 applications) and North Precinct (43 applications). When comparing the ratio of the

[1] Analysts measured officer-subject interactions rather than just the number of subjects because for some items (mental health data, subject injury data) it was important to know what each officer knew about the subject. For example: when 2 officers interacted with 1 subject the data was counted for Officer A-Subject 1 and Officer B-Subject 1. This results in two lines of data for this subject, rather than just one.

number of force applications to the number of force cases audited (application rate) for each of the three patrol precincts, Central Precinct used fewer applications of force per force case (1.6) compared to East and North Precincts (2.0-East and 1.7-North).

Total Applications of Force for Each Precinct/Division

Precinct/Unit	Baton	Control Holds w/Injury	K9 Bite	Less Lethal Bean Bag	Pepper Spray	PFA	Strikes/Kicks	Takedown	ECW	Total
Canine	0	0	5	0	0	0	1	0	1	7
Central Precinct	0	3	0	0	1	2	5	51	5	67
DVD	0	2	0	0	0	0	0	2	0	4
East Precinct	1	4	0	2	2	14	8	49	12	92
North Precinct	0	0	0	0	0	1	9	30	3	43
TOD	0	0	0	0	0	0	1	6	0	7
Traffic	0	0	0	0	0	0	0	3	0	3
Transit	0	0	0	0	1	0	1	5	0	7
Total	1	9	5	2	4	17	25	146	21	230

When comparing specific force options used for each precinct/division, the Analysts found that East Precinct officers used their ECWs (Electronic Control Weapon) more than twice as many times as North or Central Precinct officers (East-12, Central-5, North-3). In addition, East Precinct officers deployed a greater number of ECW cycles (19 cycles) than North Precinct (8 cycles) or Central Precinct (7 cycles). However, the rate of ECW use to the number of cycles deployed was greater for Central Precinct (71%) compared to East (63%) or North (38%) precincts. Use of an ECW at East Precinct was nearly evenly distributed between afternoon (6 applications) and day (5 applications) shifts. One ECW application occurred during night shift. Seven of the 12 applications of an ECW in East Precinct involved a subject who was armed with a knife/sharp object. (See section, ECW Specific – Hands on Control, Pain Compliance, Number of ECW cycles for more details.)

East Precinct officers used the PFA force option in addition to another FDCR-level force option more than the other two patrol precincts (East-14, Central-2, North-1). Thirteen of the 14 applications of PFA in East Precinct involved a subject who was armed with a firearm-actual, implied, or reported.

East Precinct officers also used the takedown force option significantly less often than the other two patrol precincts (rate of 53%-East compared to 76%-Central, 70%-North). This trend is consistent with Q1 2016 and was identified in the Q1 Force Audit Report.

The subject-officer interactions that resulted in force in East Precinct were more likely to involve an armed subject (East-35 armed subject-officer interactions compared to Central-12 armed subject-officer interactions, North-7 armed subject-officer interactions). Furthermore, East Precinct armed subject-officer interactions were at least 8 times more likely to involve a subject armed with a firearm and 2 to 3 times more likely to involve a subject armed with a knife/sharp object compared to the other patrol precincts (East-17 armed with a firearm subject-officer interactions, Central-2 armed with a firearm subject-officer interactions, North-0 armed with a firearm subject-officer interactions).

Proportionally, North Precinct officers used strikes/kicks more frequently than Central Precinct or East Precinct officers (rate of 21% compared to 8% and 9%). North Precinct had the least amount of armed subject-officer interactions, as well as the highest rate of actively resisting subject-officer interactions. A reason that North Precinct officers used strikes/kicks more frequently could not be concluded from the audit results. Further study of the cases would need to be completed to determine the cause, as the audit does not capture the needed variables, such as the time until force was used, distance between the officer and the subject, the total number of officers present, and other environmental factors.

With the exception of the takedown trend identified in East Precinct, the trends identified in use of force options this quarter are not consistent with those identified in Q1 2016. It is the analysts' opinion that due to the small number of cases, trends in use of force options should be determined using a larger dataset over a longer period of time (annually, for example).

Rate of Force Applications for Each of the Patrol Precincts

	Central Precinct	Rate of total applications	East Precinct	Rate of total applications	North Precinct	Rate of total applicatons
Baton	0	0.00%	1	1.09%	0	0.00%
Control Holds w/Injury	3	4.48%	4	4.35%	0	0.00%
K9 Bite	0	0.00%	0	0.00%	0	0.00%
Less Lethal Bean Bag	0	0.00%	2	2.17%	0	0.00%
Pepper Spray	1	1.49%	2	2.17%	0	0.00%
PFA	2	2.99%	14	15.22%	1	2.33%
Strikes/Kicks	5	7.46%	8	8.70%	9	20.93%
Takedown	51	76.12%	49	53.26%	30	69.77%
ECW	5	7.46%	12	13.04%	3	6.98%
Total	67		92		43	

De-escalation Techniques

De-escalation techniques were used in 116 of 140 cases (83%). The audit of the supervisor's review found that in 2 cases de-escalation techniques were not used when they should have been (East-1, North-1). In addition, in 1 of the 2 cases identified where de-escalation techniques were not used when they should have been, a supervisor in the command review indicated that the force may have been avoided if de-escalation techniques had been used (North-1).[2] [3]

Force Applications and Subject Resistance

The audit found that officers consistently chose force options reasonably calculated to establish and maintain control with the least amount of appropriate force when compared to the subject's resistance. The force options chosen by the officers were consistent with training and policy given the subject's described resistance.[4]

Subject Resistance and Force Option Applied

	Baton	Control Holds w/Injury	K9 Bite	Less Lethal Bean Bag	Pepper Spray	PFA	Strikes/Kicks	Takedown	ECW	Total
Active	1	7	5	0	1	14	13	97	7	145
Assaultive	0	1	0	2	1	2	12	34	4	56
Passive	0	0	0	0	0	1	0	3	0	4
Threat of immediate assaultive resistance	0	0	0	0	2	0	0	11	6	19
Threat of immediate deadly force	0	0	0	0	0	0	0	0	4	4
Unclear	0	1	0	0	0	0	0	1	0	2
Total	1	9	5	2	4	17	25	146	21	230

[2] DOJ Agreement: 74a iii
[3] DOJ Agreement: 74c vii
[4] DOJ Agreement: 74a vi

The audit found that officers did not use force against people who engaged in passive resistance that did not impede a lawful objective. In two cases, the subjects were described as passively resisting. In one case three officers used a takedown on a suicidal subject who was about to jump off a bridge. In the second case, officers made entry into a residence during a burglary in progress. Upon kicking in the front door, an officer was immediately confronted with a subject. The officer pointed their firearm at the subject and ordered them to get on the ground.

No discrepancies were found when comparing the description of the subject's resistance in the officer's reports with the supervisor's AAR. The two cases in which the supervisor described the subject's resistance as passive were the same two cases found in the analysis of the officer report data.[5]

For each officer-subject interaction, the force options used and the subject's reported resistance were analyzed to ensure that when the subject's resistance decreased, officers de-escalated to a level reasonably calculated to maintain control with the least amount of appropriate force. When looking at all of the force options used, the subject's resistance was most frequently described as active (63%). When examining only the cases with multiple force options used, the description of the subject's resistance shifted slightly to more subjects in an elevated level of resistance, such as assaultive (25%). In addition, when the subject was armed with a weapon the proportion of subject's whose resistance was described as active increased to 79% indicating that officers used multiple factors (armed subject and resistance) in determining whether multiple force options were used.[6]

The finding that officers consistently chose force options reasonably calculated to establish or maintain control with the least amount of appropriate force when compared to the subject's resistance was determined by analyzing the force and resistance documented in the officer's FDCRs and narrative reports, which were found to be comprehensive. In 99% of the cases audited during the reporting period officers described the subject's resistance in the reporting/documentation of the event. Officers wrote 190 (97%) of the required 195 FDCRs. Officers captured 209 (91%) of the force options used in their FDCRs. However, 230 (100%) of the applications of force were captured within officer narratives.[7] A detailed description of the force used to include the descriptive information regarding the use of any weapon was found in 197 (92%) of the officer reports audited.[8]

Integrity of the Data Used to Substantiate Settlement Agreement Sections 74a iii, 74a vi, 74c iv, 74c vii Findings

# of Narrative Reports that Described the Subject's Resistance	# of Required FDCRs Written	# of Applications of Force (FDCR)	# of Applications of Force (Narrative)	Detailed Description of Force Used Including Use of Any Weapon (Narrative)
193/99%	190/97%	209/91%	230/100%	197/92%

As far as subject injury is concerned, officers included a detailed description of any injury, or lack of injury to the subject in their reports in 161 of the 215 reports audited. Fifty-two officer reports did not include a detailed description of any injury or lack of injury to the subject. Central Precinct officers were more likely than the other two patrol precincts to document the subject's injuries or lack of injuries (85% of North Precinct reports audited - compared to North-68% and East-69%). YSD (Youth Services Division) officers did not include a detailed description of any injury, or lack of injury to the subject in 50% of their

[5] DOJ Agreement: 74a ii
[6] DOJ Agreement: 74a iii
[7] DOJ Agreement: 74 c vii
[8] DOJ Agreement: 74c iv

reports. Transit officers did not include the required injury information in 40% of their reports. TOD (Tactical Operations Division) officers did not include a description of the subject's injuries, or lack of injuries in 29% of their reports. (See section, Subject Injuries & Treatment Received for further information.) [9]

Force Applied and Supervisor's Review

The audit of the supervisor's review of the officer's use of force found that in 17 of 140 cases reviewed by the sergeant whether the force used was the least amount of appropriate force was not included by the sergeant. In 17 of the 140 cases the lieutenant did not include whether the force used was the least amount of appropriate force. Although they had the same number of total cases in which they did not include whether the force used was the least amount of appropriate force (17 cases), the Sergeant and Lieutenant reviews had 4 of the 17 cases in common: East – 3, Central – 1. In 8 of the 140 cases the RU manager (Reporting Unit Manager – the precinct/division captain or commander) did not include whether the force used was the least amount of appropriate force. In 2 of the 140 cases the CHO's (Chief's Office) review did not include whether the force used was the least amount of appropriate force.

Sergeants at the specialty divisions had the highest rate of not including whether the force used was the least amount of appropriate force in their reviews (YSD-100%, TOD-33%, Traffic-33%). Among the patrol precincts, the rate of sergeant reviews that did not include whether the force used was the least amount of appropriate was highest at East Precinct (20%-day shift sergeants at East Precinct were the least likely to include whether the force used was the least amount of appropriate force in their reviews). East Precinct was followed by North Precinct (8%-there was no trend found between the shifts) and Central Precinct (4%-there was no trend found between the shifts).

Lieutenants at the specialty divisions were also less likely to include whether the force used was the least amount of appropriate force in their reviews (DVD (Drugs and Vice Division)-100%, Transit-40%, Canine-20%). Among the patrol precincts, the rate of lieutenant reviews that did not include whether the force used was the least amount of appropriate force was highest at North Precinct (19%), followed by East Precinct (10%) and Central Precinct (7%).

RU managers at the specialty divisions had the highest rate of not including whether the force used was the least amount of appropriate force in their reviews (YSD-100%, Transit-40%). The rate of not including whether the force used was the least amount of appropriate force in their review was most common among RU managers at East Precinct (8%) followed by Central Precinct (2%).

Approximately 1% of the 140 cases reviewed by the CHO did not include whether the force used was the least amount of appropriate force. [10]

Command reviews identified 6 unique cases in which force may have been avoided. The most common tactic identified to potentially avoid using force was waiting for a cover officer.

[9] DOJ Agreement: 74c vii
[10] DOJ Agreement: 74a vi

(1) An officer attempted to inventory a subject and ended up using a takedown when the subject resisted. Command indicated that if the involved officer would have waited for a cover officer to arrive on scene, the subject's ability to resist would have been reduced. The officer's supervisor discussed the benefits of waiting for a cover officer to arrive on scene and noted the discussion in the officer's EIS discussion tracker.

(2) Command found that the involved officer did not properly consider time, tactics and resources available before using their ECW. The command review indicated that this deficiency may have contributed to the officer's need to use force. The officer was counseled and assigned to additional training. The findings and counseling were noted in the officer's EIS discussion tracker.

(3) An officer did not wait for cover to arrive prior to transporting a resistive subject to their vehicle. In the command review it was suggested that had the officer waited and done two on one control of the subject, the officer may not have had to use a takedown on the subject. The officer's supervisor discussed the importance of waiting for cover in this situation and the discussion was noted in the officer's EIS discussion tracker.

(4) The command review concluded in this case that force may have been avoided if the officer disengaged and waited for a cover officer to arrive. The officer's supervisor counseled the officer and the discussion was noted in the officer's EIS discussion tracker.

(5) Applying lesser force options was suggested as a means to potentially avoid using an ECW in this case. The officer's supervisor counseled the officer and the discussion was noted in the officer's EIS discussion tracker.

(6) In this case, no FDCR-level force was used; however, the subject made an allegation of excessive force. Command indicated that the allegation may have been avoided if the officer had disengaged entirely from the situation - that an arrest did not need to be made. The officer was counseled; however, the discussion was not entered into the officer's EIS discussion tracker. [11]

Decision Point Description

In the Q1 2016 Force Audit Report two data points were used to measure the decision point description of the force decision making: (1) documentation of the subject's resistance prior to the application of force and (2) documentation of alternative force options considered. After discussions with the DOJ in Q3 2016 regarding the measurement of decision point description of the force decision making, two additional variables were included in this analysis of Q2 2016 data: (3) reason for the initial police presence and (4) whether de-escalation techniques were used.

[11] DOJ Agreement: 75g

The involved officers included a description of the subject's resistance prior to the application of force in all but 2 narrative reports (East-2). Furthermore, when reviewing the officer's use of force, the supervisor included a description of the subject's resistance prior to the use of force in all 129 FDCR-level force cases audited.[12] [13]

Officers included a description of other force options that were considered in 123 of 195 FDCR-level force reports audited (63%). Seventy-three officer reports did not include a description of other force options considered. The audit found that officers working at North Precinct (46%) during afternoon shift (53% of North Precinct officer reports that did not include a description of other force options considered) were the least likely to document other force options that were considered during their force decision making. Among the patrol precincts, North Precinct was followed by East Precinct (41%) and Central Precinct (25%) officers who did not document other force options that were considered as part of their decision point description of their force making decision. The rate of officer's including a description of other force options that were considered increased when compared to the data audited in Q1 2016 (Q1 2016 – 30% compared to Q2 2016 - 63%). [14] [15] [16]

Officers consistently documented the reason for the initial police presence in their reports; with only 1 officer failing to include this detail (North-1) (less than 1% of officer narrative reports audited). In only 1 case audited during this period did the sergeant fail to document the reason for the initial police presence (Central-1) in the AAR.[17] [18]

De-escalation techniques were used in 116 of 140 cases (83%). The audit of the supervisor's review found that in 2 cases de-escalation techniques were not used when they should have been (East-1, North-1). In 1 of the 2 cases identified where de-escalation techniques were not used when they should have been, a supervisor in the command review indicated that the force may have been avoided if de-escalation techniques had been used (North-1).[19] [20]

We think these four data points provide evidence that officers and supervisors use decision point analysis to describe their force decision making, or their review of the force decision making. We think that the failure to include a description of other force options considered found in the officer's narrative is a consequence of a vague and out-of-date report-writing directive (policy) and that it can be remedied with direction from command, as well as an updated directive. The improvement seen when comparing Q2 2016 data to Q1 2016 data supports the conclusion that direction from command will improve officer report writing. Until a clear report-writing directive is published this data point (and all other officer report writing requirements specified in the DOJ Agreement) will be unsatisfactory.

[12] DOJ Agreement: 74c vii
[13] DOJ Agreement: 74c iii
[14] DOJ Agreement: 75d
[15] DOJ Agreement: 74c iii
[16] DOJ Agreement: 74c iv
[17] DOJ Agreement: 74c vi
[18] DOJ Agreement: 75f
[19] DOJ Agreement: 75g
[20] DOJ Agreement: 74c iii

ECW Specific – Hands on Control, Pain Compliance, Number of ECW cycles

ECW Deployment

In this report, ECW use is reported using 3 methods of counting. A multi-method approach is required to identify when ECW deployment data, AAR, and officer narrative reports are inconsistent:

> (1) the number of cases involving the use of a ECW (19),
> (2) the number of ECW cycles documented by the officer/supervisor in the officer's narrative report and the AAR (35 cycles), and
> (3) the number of ECW cycles indicated by the ECW download report (35 cycles). The number of cycles indicated by the ECW download report is determined by looking at the total number of seconds for each ECW trigger pull and dividing by 5 seconds. For example, a ECW trigger pull lasting 15 seconds, is counted as 3-5 second cycles, or a ECW trigger pull lasting 6 seconds is counted as 2-cycles (1-5 second and 1-1 second). This method of counting ECW cycles is in accordance with and documented in PPB policy.

In Q2 2016 there were 19 cases in which an officer applied an ECW (13% of audited cases) to a subject. This is a decline from Q1 2016 percentage of ECW cases (19%). During the Q2 audit period, 21 officers applied 35 cycles of an ECW to subjects. Resulting in an average ECW rate of 1.66 cycles per officer who used an ECW.

In 2 cases (10% of ECW, 1.4% of overall) the number of ECW cycles listed on the officer report were not consistent with the number of cycles on the 940/AAR report. In the first case (from East Precinct) the officer reported using two cycles, and the ECW download showed 3 cycles applied. In the second case (from North Precinct) the officer reported using 6 cycles, and the ECW download showed 5 cycles applied. In both cases, the reason for the discrepancies were determined and resolved appropriately.

In 2 cases (East/day, East/afternoon), no ECW download document could be found. In one of these cases (East/afternoon) the Officer reported applying 1 ECW cycle to the subject and this report was consistent with the number of ECW cycles reported on the AAR. In the other case (East/day) the officer reported applying 3 ECW cycles to the subject. This report was not consistent with the number of cycles listed on the AAR, on the face sheet of the AAR the sergeant counted this officer's ECW use as 2 cycles. In the sergeant's review of the case, he acknowledged that the officer applied 3 cycles (Of note: the context of this discrepancy is important, the sergeant was assessing and documenting 8 ECW cycles applied by 3 different officers to an armed and resistive subject).

In no cases were there any discrepancies between the officer narrative and the AAR with regard to how the ECW was deployed (probe-deployment v. drive stun deployment). [21]

East Precinct applied two times more ECW cycles to subjects than any other precinct. However, officers at East Precinct also interact with more armed subjects than officers in any other precinct. We would caution against generalization of trends from this data as it is a small set from a short time period. See Force Applications and Officer Precinct/Division section for more details.

[21] DOJ Agreement: 74b i

Number of Cycles Applied by Precinct

	1 cycle	2 cycles	3 cycles	4 cycles	5 cycles	6 cycles
Canine	1	0	0	0	0	0
Central	3	2	0	0	0	0
East	8	2	1	1	0	0
North	2	0	0	0	0	1

ECW Reasonableness and Justification

In 3 cases, supervisors found that the first ECW cycle applied was not justified (North/afternoon-1, East/day-1, Central/day-1). In the case from East Precinct, the ECW deployment was found out of policy. The officer failed to give an ECW warning and then applied the ECW to the subject while a fence was between the officer and subject. No additional ECW cycles were applied, and the case was referred to IAD (Internal Affairs Division) for full investigation. In the case from North Precinct, there was a discrepancy around the officer's first deployment that was resolved by the chain of command and eventually found to be justified and within policy.

As for the case from Central, the officer's first application of the ECW was found out of policy. The officer applied the ECW to the subject while the subject was running away, heightening the risk of a secondary injury to the subject. Upon review, members of command found that the subject's behavior was not threatening in a manner which justified the use of the ECW. And finally, it was determined that the officer violated PPB policy for attempting to handcuff the subject alone and while the ECW was still in his hand. The officer will receive a refresher class in ECW deployment and either a letter of counseling or a formal letter of expectation.[22]

Hands-on Control and Documentation of Environmental Factors

Overall, officers successfully documented the environmental factors and context that they considered when applying their ECWs. In 2 officer reports (East/day-1, Canine/night-1), officers did not document the amount and type of resistance they encountered. The case from East day was, subsequently, found to be out of policy. The case from Canine, though the report was vague, was deemed in policy.

In 3 officer reports (East/afternoon-2, Central/afternoon-1), officers did not document the severity of the reason for attempting to control the subject. In one case, during the AAR review, the lieutenant sent the AAR back to the sergeant to require the involved officer to submit a more detailed report. In all three of these cases, the ECW use was found to be in-policy.

Officers accurately documented the practicality of hands-on control. Analysts found 1 cycle (North/ afternoon) where the officer's narrative did not contain sufficient articulation to determine whether or not hands on control was practical. In cases where hands-on control was practical (8), officers documented that they used hands-on control in 14 of 15 applied cycles.[23]

ECW Pain Compliance and Rational Response

Drive stun cycles are applied to achieve pain compliance from resistant subjects. Officers applied 6 drive stun cycles to 4 different subjects in 4 different cases. In 3 of these cases, 5 drive stun cycles were

[22] DOJ Agreement: 74b ii
[23] DOJ Agreement: 74b iii

applied to subjects that were not in mental health crisis. All 5 drive stun cycles were applied to achieve pain compliance. In 1 case a drive stun cycle was applied to a subject suffering from a mental health issue. In this case (East/afternoon) the subject suffered from a mental health issue. This information was not known to the officers at the time of the use of force and was disclosed to the sergeant during the force investigation. The investigating supervisor found that the drive stun applied to this subject was done so in order to prevent a higher level of force. [24]

Reporting Requirements – Officer, Sergeant, Subject, and Witnesses

The most common reporting issues identified by the audit were failing to document the subject's injuries or lack of injuries (52 of 215 reports), failing to include any description of other force options considered (73 of 195 FDCR-level force reports), and failing to consistently make diligent efforts to identify witness observations (101 of 215 reports audited).

In all but 4 reports audited, officers included a detailed description of the unique characteristics of the event (North-2, East-1, Transit-1). Officers used common everyday language, for example, they did not use undefined acronyms, technical terms, or call codes in all narratives audited.[25]

In nearly 97% of cases (125) sergeants found that officer reporting was a complete and accurate account of the force decision making. In 2 cases (both from North/afternoon) sergeants found that the officer's decision making was not a complete and accurate account of the force decision making. In one of these cases, officer's reports were vague because the investigation was delayed. Initially, the officer's actions were not considered a takedown, but after review by PSD (Professional Standards Division) (due to notification on mental health component) an After Action was ordered to be completed. In their review the sergeant noted, "Due to the time delay of this report, the effectiveness of the critique and evaluation that is applied in this report will be hampered. The officer's fragmented recollection of the force used is reasonable due to the minimal level and the 2 month time delay." In the other case, the sergeant noted several reporting requirements that the officer left out of their narrative and FDCR. The sergeant instructed the officer to write a supplemental report to address the missing reporting requirements.

In 2 cases a member of the chain of command indicated that the officer's narrative did not describe the subject's behavior. A sergeant identified this in a case from DVD; and spoke with the officer about their reporting and made an EIS entry for the officer. A lieutenant identified this in a case from North/afternoon. The lieutenant notified the officer's sergeant and both agreed that the reporting was problematic; the officer received an EIS entry for the incident.

In less than 1% of reviews (5) supervisors indicated that an officer's narrative did not include a justification for the force used. All four levels of supervision identified 1 case (Central/day) where the officer's narrative did not include a justification for the force used. In this case, an officer applied an ECW twice. All supervisory members found the officer's first ECW cycle unjustified and out of policy. The officer's sergeant arranged for the officer to attend additional ECW Training and the CHO sent a

[24] DOJ Agreement: 74b iv
[25] DOJ Agreement: 74c ii

request to PSD for review of the incident. A lieutenant identified a second case (North/afternoon), in which an officer applied an ECW, but the sergeant found that the officer did not articulate the threat posed by the subject at the time. The lieutenant and sergeant met with the officer to discuss their report writing (also identified as problematic in its description of the subject behavior) and an EIS entry was made.

In all cases audited during this period, supervisors found officers included a description of the totality of the circumstances that existed. And in no cases audited during this period did any supervisor's review indicate that a witness officer failed to complete a narrative report.

Officer-Level: Subject Injury Documentation

Officers included a detailed description of any injury, or lack of injury to the subject in their reports in 160 of the 215 reports audited. In 26% of narrative reports officers did not document any subject injury. The majority of the time officers did not document subject injury was because the subject was uninjured and they did not write about the lack of injury in their narrative report. Fifty-five officer reports did not include a detailed description of any injury or lack of injury to the subject. Central Precinct officers were more likely than the other two patrol precincts to document the subject's injuries or lack of injuries (15% of Central Precinct reports audited were deficient - compared to North-32% and East-31%). YSD officers did not include a detailed description of any injury, or lack of injury to the subject in 50% of their reports. Transit officers did not include the required injury information in 40% of their reports. TOD officers did not include a description of the subject's injuries, or lack of injuries in 29% of their reports.

Officer Level Information – FDCR Subject Injury		**Officer Level Information – Subject Injury Documented in Narrative**	
Blank	16	Blank	55
None	98	None	66
Bruises	22	Bruises	10
Abrasions	66	Abrasions	56
Lacerations	17	Lacerations	20
Broken Bones	0	Broken Bones	0
Other Injury	22	Other Injury	24

In their FDCRs, officers were consistent in documenting injury to subjects as well as the lack of injury to subjects with only 16 of 215 (7%) of officers failing to document subject injury in their FDCR.

Officers adequately documented treatment received by subjects. In cases where no treatment was needed because of lack of injury, officers consistently documented this correctly by leaving the subject treatment blank. Most frequently (38% of the time) subjects were treated at the scene by Emergency Medical Services (EMS). Five subjects were treated by EMS at the precinct. In two of these cases this was because the subject injured themselves in the police car. In one case the subject's injury wasn't apparent until they arrived at the precinct. In two cases this was because the force event took place at the precinct. In 24 cases officers documented that the subject of force was taken to the hospital. In half of these cases (12) the subject was treated and released and in half of these cases (12) the subject was

admitted to the hospital. In 21 cases the subject engaged in self-treatment (5) or refused treatment (16). [26]

Event – Level: Subject Injury Documentation

In 73 (50%) cases, the sergeant investigating the force event selected that a medical response was necessary for the subject's injuries. In 44 cases, medical was requested for injuries sustained by the subject related to the force event. In 10 cases, medical was requested for self-inflicted injuries. Of the remaining cases, medical was summoned for drug/alcohol related issues (11), mental health issues (11), and pre-existing injuries (20). In some cases a medical response was summoned for more than 1 reason. There were no cases where it was unclear why a medical response was requested. The AARs documented the subject treatments: EMS at scene (62), EMS at precinct (4), Hospital – Admitted (19), Hospital – Released (16), Treatment Refused (4), and Self-Treatment (1). These numbers differ slightly from the treatment documented by officers because the investigating sergeant has more knowledge of the injury and treatment received (often determined after the force event) than the officers involved in the force event. The audit found that supervisors were accurate in their capturing of the necessity of medical attention and the type of treatment the subjects received.

In 5% of the cases audited during this period the sergeant did not attempt to obtain a statement from the subject detailing the event and any injuries (East-4, North-2, Canine-1, YSD-1). In 1 case the subject was unconscious (sedated by medical). In 1 case the subject fled and was not located. In 1 case the interview was delayed for a day and was conducted by detectives. In 2 cases (East/night and North/afternoon) reports indicate that the subject was available but there was no explanation as to why the subject was not interviewed. In 3 cases (East/night, North/afternoon, and YSD) the sergeant was not notified of the incident in a timely manner and so could not interview the subject. This is much improved over last quarter, where sergeants failed to attempt to obtain a statement from the subject in 11% of cases audited.[27]

Witness Documentation

The audit found that officers included a general description of force they observe another officer apply in 113 of 195 FDCR level reports audited (20 officer reports audited were a result of a complaint of injury and FDCR-level force did not occur). Seventy-six reports involved officers who did not witness another officer use force, either because they were the only officer involved or documented that they were not able to see the force applied by another officer. In 5 reports an officer witnessed force that another officer applied and did not document it within their report.[28]

It is not documented in PPB directives that witness officers complete a separate narrative supplemental report. But, it is PPB policy that a witness officer's statement be included in the AAR. In no cases audited during the reporting period did any supervisor's review indicate that a witness officer failed to complete a narrative report. In 3% of cases audited (5 of 140) did the sergeant did not personally speak to the involved witness member (to make an inquiry sufficient to describe the nature of the force and the member's justification and document these in the AAR (Central-1, North-2, Canine-1, and Transit-1)).[29]

[26] DOJ Agreement: 74c v
[27] DOJ Agreement: 75c
[28] DOJ Agreement: 74c x
[29] DOJ Agreement: 74c x

One hundred three (74%) cases audited during the reporting period had citizen witnesses, and in 101 of those cases, the investigating sergeant documented the witness account of the event. In 2 of the 140 cases reviewed, a sergeant failed to document the witness(es) account of the event (East-1, Central-1).

Whether the witness name and contact information was included in the AAR was audited. In 85 cases (61%) the sergeant included both the name and manner of contact for the witness. In 18 cases the sergeant provided only the name of the witness, but no contact information. In 2 cases the sergeant did not include the name or the manner of contact for the witness.

In 37 cases there were no citizen witnesses. The sergeant provided an explanation about the circumstances that prevented them from identifying witnesses or obtaining contact information in 34 of those cases. The sergeant indicated that a witness refused to provide a statement in 12 cases.[30]

Officers included in their reports that they consistently made diligent efforts to identify witness observations in 108 of 215 reports audited. One hundred one officer reports did not indicate that officers made diligent efforts to identify witness observations. Among the 3 patrol precincts, North Precinct officers were less likely to document witness observations or that they made an effort to do so (63%). East Precinct officers did not document that they consistently made an effort to identify witness observations in 53% of the East Precinct reports audited. Central Precinct officers did not document that they consistently made an effort to identify witness observations in 25% of the Central Precinct reports audited. Of the specialty divisions, YSD officers did not document that they consistently made diligent efforts to identify witness observations in 2 of 2 reports audited. TOD officers did not include efforts to identify witness observations in 6 of the 7 reports audited. Transit division officers included the information in 1 of 5 reports audited. Traffic and Canine officers did not include efforts to identify witness observations in 50% of their reports.

Officers included an explanation when circumstances prevented them from identifying witnesses or obtaining contact information in 23 of the 215 (11%) reports audited.[31]

Timeliness of Reporting

FDCR Timeliness

The following only includes FDCRs that were submitted. Missing FDCRs are addressed in the Officer Reporting Requirements section of this document. One hundred eighty-seven (87%) of all FDCRs were submitted either the day of or the day after the event. This is an increase over last quarter (79% same day/next day).

Five (2%) FDCRs were submitted between 2 and 10 days post-event. This is more than last quarter, and is perhaps reflective of instruction received from supervisors to submit an FDCR for an event that an officer, initially, did not consider an FDCR-level force event.

One FDCR (North/day) was filled out 30 days or more after the event. In this case, officer reports were reviewed by PSD (due to the initial notification) and PSD indicated that an After Action needed to be

[30] DOJ Agreement: 74c xi
[31] DOJ Agreement 74c xi

completed. Upon completion, this officer was required to submit an FDCR. This is an improvement from last quarter's audit where there were 2 FDCRs submitted more than 30 days after the force event.[32]

After Action Report (AAR) and Review Timeliness

The cases were audited to determine whether supervisors consistently complete a Supervisor's AAR within 72 hours of notification. Only the date was used to determine timeliness; a timestamp was not available, therefore all AARs that were completed within 3 days met the 72 hour timeline. Directive 940.00 indicates that exceptions to the 72 hour requirement are allowed and must be approved by the RU manager and the approval must be documented in the AAR. Policy guidelines dictate that RU managers must complete a review of the event no later than 21 days after the event, and the CHO must complete a review of the event no later than 28 days after the event.
The lieutenant does not have a timeline in which to complete their review – although the review needs to be completed within 21 days of the event for the RU manager to meet their timeline.

Thirteen AAR timelines were missed during the Q2 2016 audit period, for a missed timelines rate of 2.3%. The number of AARs that missed timelines is consistent with our findings from last quarter (Q1 2016 - 12 missed timelines, 2.6%).

AARs for 3 cases were overdue at the sergeant level, missing the 72 hour deadline. In 1 of these cases (North/afternoon) the sergeant missed the deadline because there was a misunderstanding around the definition of a takedown. In 1 case (East/day) the RU manager approved the delayed AAR. One case (YSD) the sergeant missed the 72 hour deadline with no explanation provided.

AARs for 5 cases were overdue at the RU manager level. Two of these cases came from East Precinct (East/day and East/afternoon), 1 from North (North/afternoon- same case that missed the sergeant timeline), 1 from Traffic and 1 from Canine.

AARs for 5 cases were overdue at the CHO level. Two of these cases were from East (East/day and East/afternoon- the same cases that missed the RU manager timelines), 1 was from North (North/afternoon- the same case that missed the sergeant and RU manager timeline) and 1 was from Canine (also missed the RU manager timeline). There was a case from Transit that was overdue at the CHO level.[33]

In/Out of Policy

Supervisor Evaluation of the Evidence

To verify that supervisors arrived at their decisions based on the evidence available, the audit examined whether the supervisors noted missing evidence in their reviews.

During the Q2 audit period, supervisors (lieutenant, RU manager, and CHO) identified 1 case (East/day) in which an officer failed to complete an FDCR for a takedown that was applied. This period of review contains 5 cases where a sergeant failed to identify a missing FDCR (East/day, East/afternoon, Central/day, Central/afternoon, Transit/day). There were 4 cases where the lieutenant failed to identify a missing FDCR (East/afternoon, Central/day, Central/afternoon, Transit/day) The RU manager indicated

[32] DOJ Agreement: 74c i
[33] DOJ Agreement: 75a

that an officer failed to complete an FDCR in 1 case (East/day), but did not indicate that an officer failed to complete an FDCR in 4 cases (East/afternoon, Central/day, Central/afternoon, Transit/day). The CHO indicated that an officer failed to complete an FDCR in 1 case (East/day) but did not indicate that an officer failed to complete an FDCR in 4 cases (East/afternoon, Central/day, Central/afternoon, Transit/day).

Summary of Missing FDCRs Not Addressed by Supervisors

Sergeant	Lieutenant	RU Manager	CHO
5 FDCRs	4 FDCRs	4 FDCRs	4 FDCRS

This reporting period had 4 cases where no member of command indicated that an officer failed to complete an FDCR. One of these missed FDCRs was for PFA (East/afternoon), the other 3 were for the application of takedowns (Central/day, Central/afternoon, Transit/day). This highlights an issue regarding the working definition of takedown. Excluding officer-subject interactions for complaint of injury cases (which would not require FDCRs), the reporting period had 195 officer-subject interactions that generated FDCRs. For this reporting period, 2% of FDCRs were missing. This is down from last quarter, were 2.7% of FDCRs were missing.[34]

In 3% of cases audited during this period (5/140) the sergeant did not personally speak to the involved witness member(s) to make an inquiry sufficient to describe the nature of the force and the member's justification and document these in the AAR (Central-1, North-2, Canine-1, and Transit-1).[35]

Overall, there were 5 cases where photos were missing from DIMS (Digital Image Management System). In 2% of reviews (14) a supervisor indicated that the investigating supervisor failed to photograph the scene or subject. In 3 cases the sergeant acknowledged his/her failure to take photos (East/night - notification was made late, so it was not possible to photograph the subject. North/afternoon – the sergeant forgot to take pictures prior to transport of subject to MCDC (Multnomah County Detention Center). The sergeant used discretion to rely on booking photo and retail store footage of the event. TOD/afternoon – the sergeant did not take pictures of the subject because there was no injury to the subject and he did not realize it was PPB policy to document the lack of injury to a subject). The lieutenant identified missing photos in the 3 previous cases plus an additional case (North/afternoon) where the sergeant did not take photos because they did not think that the event was an FDCR-level event. The RU manager identified the 4 cases that the lieutenant identified plus an additional case, (East/day) whereby the sergeant did not take photos. The RU manager instructed the lieutenant to remind the sergeant to take photos of the scene and an EIS entry was made for the sergeant regarding the missing photos. The CHO identified 2 cases missing photos, these cases had already been identified as missing photos by other levels of review. This is also much improved over last quarter, where 12 cases were missing photographic evidence.

There were 2 cases in which the supervisor's review indicated that there was a failure to collect video evidence. All levels of command identified 1 case where a sergeant failed to collect video evidence. The lieutenant, RU manager, and CHO all identified the same case as missing video evidence (East/afternoon- the detective had video but failed to preserve it. This was addressed by the detective's

[34] DOJ Agreement: 75b
[35] DOJ Agreement: 75c

supervisor). The lieutenant identified a case from East/day where a witness had video of the event and at the time of the supervisors review, it still had not been acquired and uploaded into DIMS. [36] [37]

When rendering a determination of whether or not an event is within policy, reviewers must consider the weight of the evidence. The SA (settlement agreement) refers to this as, "measure[ing] the evidence of the officer's account versus the evidence of the subject's and witnesses accounts to determine whether the weight of the evidence supporting the officer's account was greater than any other alternative account." The audit found that the sergeant did not do this in 6 of 140 cases reviewed, the lieutenant in 4 of 140 cases reviewed, the RU manager in 5 of 140 cases reviewed, and the CHO in 5 of the 140 cases reviewed.

Determination of Whether the Force Used was In or Out of Policy

During the Q2 2016 auditing period, 5 cases (3.5%) were identified by command as out of policy (East/day-1, East/night-2, Central/day-1, Central/afternoon-1). Three of these cases were related to the officer's use of an ECW (see section ECW Specific – Hands on Control, Pain Compliance, Number of ECW Cycles for additional details). In 2 of these cases the out of policy findings were related to overall satisfactory performance.[38] This is consistent with last quarter, where approximately 3.5% of cases audited were also found out of policy.

Modified Findings

There were no cases in which the command review indicated they modified their findings.[39]

Mental Health

There were 49 cases (35%) that were identified as having a mental health influence. These 49 cases generated 79 unique officer-subject interactions (Central-38, East-19, North-18, Transit-1, Traffic-1, and YSD-2), accounting for 36% of the overall officer-subject interactions. Excluding COI cases, these interactions generated 64 FDCRs. On these FDCRs, 51 officers (79%) indicated that the subject was exhibiting a mental health issue, 3 officers (4%) indicated that the subject was not exhibiting signs of a mental health issue and 10 (15%) were left blank or marked as unknown. On the 3 FDCRS (from 2 cases in Central Precinct) where "no" was selected for subject's mental health status, it was later determined that the subjects were experiencing a mental health issue after the event. In both cases this information was discovered by the sergeant during their interview with the subject. [40]

Where officers indicated that the subject was exhibiting signs of a mental health issue (51 FDCRs), analysts found that 54% (28) of the time these officers also indicated within their narratives that they had knowledge of the subject's mental health issues prior to their use of force. This reporting requirement shows marked improvement over last quarter (Q1 2016 - 24%). For this auditing period, 45% (23) of officer narratives failed to include this information in their narratives (Central-14, East-3, North-6).

[36] DOJ Agreement: 75c
[37] DOJ Agreement: 77a
[38] DOJ Agreement: 75e
[39] DOJ Agreement: 77c
[40] DOJ Agreement: 74c ix

Analysts found 49% (25) of officer narratives indicated that the subject's mental health issues influenced their decision making. Fifty-one percent (26) of officer narratives failed to include this information (Central-12, East-4, and North-10). This reporting indicator is consistent with last quarter and is likely due to a vague reporting requirement and minimal direction about including how the information affected decision making. We expect that with additional training/direction, the satisfaction of this reporting requirement will improve. [41]

Finally, analysts identified 1 case where an officer marked on the FDCR that they were interacting with a subject experiencing a mental health influence, but the sergeant did not indicate this on the AAR mental health checkbox. Upon further investigation, we discovered this was a coding error generated during the audit process. Officers involved in this case indicated there was no mental health influence on their FDCRs. Overall, this suggests that officers and sergeants are consistent in their interpretation of the perception of or identification of actual mental illness within subjects. Last quarter we were unable to identify discrepancies between officer-level identification of mental health information and case-level identification. This quarter's ability to do so is reflective of improvement to the audit methodology.

Subject Injuries & Treatment Received

Officer Documentation of Subject Injury & Treatment Received in FDCR and Officer Narrative[42]

Subject Injury	FDCR	Narrative		Treatment Received	FDCR
Blank	16	55		Blank	82
None	98	66		EMS at Scene	94
Bruises	22	10		EMS at Precinct	5
Abrasions	66	56		Hospital – Admitted	24
Lacerations	17	20		Hospital – Released	24
Broken Bones	0	0		Treatment Refused	16
Other	22	24		Self-Treatment	5

Officers reported 105 bruises, abrasions, and lacerations in their FDCRs and 86 bruises, abrasions, and lacerations in their narrative reports. There was no case audited during Q2 2016 where a subject sustained a broken bone. While officers generally documented subject injury on their FDCRs (8% did not), they did not document subject injury within their narrative reports 26% of the time. In general officers were most likely to fail to document the lack of subject injury, but also failed to document bruises about half of the time within their narrative report. The number of officers who did not document the lack of injury within their narrative report has decreased when compared to the previous quarter's audit report. We estimate this number will continue to decrease with improved report writing directives.

We have identified that officers are often unaware of the extent or treatment of injuries because identification of injuries and treatment often occur after an officer has cleared from an incident. Additionally due to differences in injury perception (an abrasion may be labeled a laceration or vice versa) there are expected discrepancies between the reporting of a subjects injuries. We encourage the development of additional trainings around the definitions of injury types in order to maximize the consistency and documentation thereof. We are encouraged to find no large gaps in the reporting of

[41] DOJ Agreement: 74a i
[42] DOJ Agreement 74a v

subject injury and treatment received and that the treatment received seems to be proportional to the types of injuries that are sustained.

The methodology used for this quarter's audit does not address timeliness of medical procurement due to the inability to verify the exact time that medical was requested. Our best approximation is to rely on the supervisor to identify and document cases where medical response was not procured in a timely manner. For the next audit (Q3 2016) we have revised our questions to capture what time medical response was requested by using CAD (Computer Assisted Dispatch) call data obtained from BOEC (Bureau of Emergency Communication). When this is compared to the approximate time the force event occurred, we will be able to determine whether or not medical treatment was procured in a timely manner. [43]

Specialty Units

Additional specialty units were activated in 19% of cases audited. This does not include cases where specialty unit officers were initially dispatched to the scene, and is a slight increase compared to Q1 2016 (16%). The Canine Unit was the specialty unit activated by officers on-scene most frequently (15 officers reported activation of this unit), followed by ECIT (Enhanced Crisis Intervention Trained) (8 officers reported activation of this unit).

Twenty-two percent (50) of the officers dispatched to calls during this period were ECIT officers. This is a slight increase over last quarter, where 19% of all responding officers were designated ECIT. Relative to the activation of specialty units, the most common conditions present and cited in officer narratives were (1) a mental health component and the subject is violent (cited by 17 officers), (2) tactical apprehension of a subject is needed (cited by 17 officers), and (3) mental health component and the subject has a weapon (cited by 16 officers). Mental health related conditions were the most common cause for activation of specialty units last quarter as well.

The audit identified 49 cases with a mental health component, in 30% (15) of these cases at least one of the officers involved in the force event was also an ECIT officer. This likely underreports the number of involved ECIT officers as the methodology doesn't require the coding of the reports of officers who may have been on-scene but weren't involved in the force events. The number of cases identified with a mental health component is higher this quarter (35% of overall cases audited) than last quarter (30% of overall cases audited).

In 98% of the cases audited during this period, specialty units were activated appropriately. In only 3 cases (2%) did supervisors find that specialty units were not called when they should have been (East-2, North-1). In 2 of the 3 cases, sergeant's reviews indicated an ECIT officer should have been called. In both of these cases the sergeant discussed with the reporting officer the value of activating an ECIT officer and in one case an EIS entry was made for the officer's failure to do so. In the third case, the sergeant's review suggested activating a Canine Unit rather than engaging in a foot pursuit. In no cases did supervisors indicate that specialty units were activated when they shouldn't have been. Last quarter supervisors identified 1 case where a specialty unit was not requested according to procedure. [44]

Notification Requirements

[43] DOJ Agreement: 74c v
[44] DOJ Agreement: 74a iv

A case is defined as a serious use of force case if it has any of the following factors: (1) all uses of force by a member that reasonably appear to create or do create a substantial risk of death, serious disfigurement, disability, or impairment of the functioning of any body part; (2) all critical firearm discharges by a member; (3) all uses of force by a member resulting in a significant injury, including a broken bone, an injury requiring hospitalization, or an injury deemed to be serious by a member's supervisor; (4) all head, neck and throat strikes with an object or carotid neck holds; (5) force event, complaint of excessive force or a complaint of injury involving a person known or reasonably assumed to be under fifteen (15) years of age, and females known or reasonably assumed to be pregnant; (6) all uses of force by a member resulting in a loss of consciousness; (7) more than two cycles of an electronic control weapon, regardless of outcome on an individual by one or more members during a single interaction; (8) any strike, blow, kick, electronic control weapon system cycle, or similar use of force against a handcuffed, otherwise restrained, under control, or in custody subject, with or without injury; (9) any use of force referred by a member's supervisor to IA which IA deems serious. A shift supervisor and the PSD must be notified of every serious use of force case.

Thirteen of the 140 cases audited (9%) during Q2 2016 were serious use of force cases. The most common serious use of force factor documented in the command review was any strike, blow, kick, ECW cycle, or similar use of force against a handcuffed, otherwise restrained, under control, or in custody subject, with or without injury. Cases that were identified as serious use of force cases were distributed in the following precincts/divisions: East-6, Central-2, North-2, Canine-1, TOD-1, and YSD-1. The audit of the AAR found that in 2 of the 13 serious use of force cases, notification of PSD was not documented. Investigating sergeants did not articulate the notification of their shift supervisor in 10 of the 13 serious use of force cases audited. East Precinct supervisors were the least likely to document whether a shift supervisor was notified (4 cases).[45]

In addition to notifying PSD and a shift supervisor for serious use of force cases, supervisors must notify whenever evidence of apparent criminal conduct or evidence of a Graham Standard violation by an involved member is found. The sergeant's summary in the AAR indicated that they notified PSD in 59 of the 140 cases audited. In 3 of the 59 cases, the sergeant indicated that the reason for the notification was criminal conduct, or allegation of criminal conduct. In 2 of the 59 cases the sergeant indicated that the reason was misconduct. Other reasons for notifying PSD found documented in the sergeant's summary: use of force against a person with actual or perceived mental illness (44), serious use of force (10), other (3). The sergeant's summary in the AAR indicated that they notified a shift supervisor in 26 of the 140 cases audited. In 6 of the 26 cases, the sergeant indicated that the reason was criminal conduct, or allegation of criminal conduct. In 1 of the 26 cases, the sergeant indicated that the reason was misconduct. Other reasons for notifying the shift supervisor found documented in the sergeant's summary: use of force against a person with actual or perceived mental illness (18), serious use of force (2), other (3). [46]

We think that the difference found in documenting whether PSD was notified and whether a shift supervisor was notified is due to vague reporting directives and documentation inadequacies; that sergeants may not be aware of the need for articulation of supervisor notification in the same way that they articulate the PSD notification in the AAR.[47]

[45] DOJ Agreement: 75k
[46] DOJ Agreement: 75l
[47] Sergeants received an email from A/C Day requiring the notification of a shift supervisor anytime a notification was made to PSD. This is the extent of instruction that sergeants received regarding supervisor notification.

The audit methodology has been modified and beginning in Q3 2016, we will be able to more accurately report the total number of serious use of force cases and compare that number to the number of cases in which the sergeant documented PSD and shift supervisor notifications due to the serious use of force.

The audit found that in all cases in which the investigating supervisor, shift commander or division commander found evidence of apparent criminal conduct by a PPB officer the investigation was suspended immediately and the branch assistant chief, director of PSD, and the Detectives Division were notified. In 2 of the 140 cases audited either the investigating supervisor, shift commander, or division commander found evidence of apparent criminal conduct by a PPB officers and suspended the investigation and made the appropriate notifications.[48]

In all cases in which an investigating supervisor, shift commander, or precinct commander found evidence of apparent misconduct by a PPB officer, or employee, the matter was reported to PSD for review and investigation. In 1 of 140 cases audited either the investigating supervisor, shift commander, or precinct commander found evidence of apparent misconduct by a PPB officer, or employee and the matter was reported to PSD for review and investigation.[49]

EIS and Tactical/Training Issues Identified

Supervisors Request Additional Investigation when Necessary

In 78% of the cases audited (111) it did not appear that there was any additional relevant evidence to assist in resolving inconsistencies, so the request for additional investigation was not necessary. In 6 cases (East-2, Central-2, DVD-1, and Canine-1) the supervisor requested additional investigation when it appeared that additional relevant evidence existed which would resolve inconsistencies. This is an increase from Q1 2016 where sergeants only requested additional investigation in 3 cases (2.0%).

In 10% (14) of cases, sergeants did not request additional investigation, but another member in the command structure did (East/day-3, Central/day-1, Central/afternoon-1, Central/night-1, North/day-3, North/afternoon-1, North/night-1, Transit/day-1, TOD/afternoon-1, and Traffic/night-1).

In 6.4% (9) of cases, no member of command requested additional investigation when auditors found that there was reason to (East/night-2, Central/afternoon-1, Central/day-1, North/afternoon-1, North/day-1, Transit/day-1, Transit/afternoon-1, and YSD-1). This is a significant decrease from last quarter. This is likely representative of increased clarity in coding methodology, as well as increased scrutiny and clarity of expectations among reviewing members of command. [50] [51]

Corrective Action Documented in EIS

Last quarter's audit results documented supervisor failure to use EIS to document training deficiencies, policy deficiencies and/or poor tactical decision making. This quarter's findings suggest that supervisors show improved documentation of these deficiencies in the officer's EIS discussion tracker, but could benefit from additional instruction around documentation of corrective action/officer reporting. We

[48] DOJ Agreement: 77f
[49] DOJ Agreement: 77g
[50] DOJ Agreement: 77d
[51] DOJ Agreement: 77b

expect that with a revised reporting writing directive and enhanced supervisor training, reporting on this indicator will improve.

The audit found a significant number of cases in which the supervisor's review did not address errors/inaccuracies or missing information in the officer's reports and so failed to take corrective action to address those errors: sergeant - 83 cases reviewed, lieutenant - 68 cases reviewed, RU manager - 71 cases reviewed, CHO - 65 cases reviewed. Sergeants were the least likely to address errors/inaccuracies or missing information and so failed to take corrective action to address those errors. The sergeants at East Precinct did not address, or take corrective action in their review of 32 of the 34 East Precinct cases in which any of the officer reports contained errors/inaccuracies or were missing information. The sergeants at Central Precinct did not address, or take corrective action in their review of 20 of the 29 Central Precinct cases in which any of the officer reports contained errors/inaccuracies or were missing information. The sergeants at North Precinct did not address, or take corrective action in their review of 21 of the 24 North Precinct cases in which any of the officer reports contained errors/inaccuracies or were missing information.

When corrective action was taken for any material omissions or inaccuracies in officer's reports, the lieutenant was more likely to address the issue in their review and take corrective action: sergeant-16 cases reviewed, lieutenant-20 cases reviewed, RU manager-17 cases reviewed, CHO-16 cases reviewed.

A supervisor in the command review indicated corrective action was taken for failing to report a use of force, whether applied, or observed in 4 of 129 cases involving FDCR-level force. There was no trend found in which level of command was more likely to take corrective action for failing to report a use of force, whether applied, or observed. [52] [53] [54]

EIS entries for officers are required to include the following detailed items; (1) the case number of the incident, (2) the nature of the incident and, if applicable, the type of force used, (3) the policy outcome, (4) any positive performance by an officer, (5) any training deficiency, policy deficiency or poor tactical decisions made by officers.

One hundred ninety-two officers' EIS entries included the case number. The audit found that 16 officer's EIS entries did not include the case number. Supervisors of officers assigned to specialty units were less likely to include the case number in the officer's EIS discussion tracker: Canine-4, TOD-4, Traffic-1, and YSD-1.

One hundred ninety-six officers' EIS entries included the nature of the incident and, if applicable, the type of force used. Twelve officer's EIS entries did not include this information. Again, supervisors of officers assigned to specialty units were less likely to include this information in the officer's EIS discussion tracker: Canine-2, North-4, TOD-4, Transit-1, and YSD-1.

One hundred ninety-eight officers' EIS entries included whether the incident was within policy. Ten officer's EIS entries did not include whether the incident was within policy (2-Canine, 5-North, 1-Traffic, 1-Transit, 1-YSD).

The audit identified that for officer EIS entries, when a training deficiency, policy deficiency, or poor tactical decision was identified in the AAR, the EIS entry contained the information in only 36 of the total

[52] DOJ Agreement: 75j
[53] DOJ Agreement: 77e
[54] DOJ Agreement: 75i

215 EIS entries audited. Sergeants at North Precinct were the least likely (15 of 41 EIS entries - 37%) to include poor tactical decisions, training and policy deficiencies that were identified in the AAR in the officer's EIS discussion tracker. North Precinct sergeants were followed by Central Precinct (18 of 69 EIS entries - 26%) and East Precinct (21 of 78 EIS entries - 27%) sergeants.

The audit identified that for supervisor EIS entries, when a training deficiency, policy deficiency, or poor tactical decision was identified for supervisors, the EIS entry contained the information in 28 of the total EIS entries audited. The CHO level was most deficient in EIS entries (entries that should have been made, but were not), with 12 missing EIS entries (48%). The audit identified 7 cases where EIS entries should have been made for the RU manager (Central-2, North-4, and YSD-1) but were not and 6 cases where EIS entries should have been made for the lieutenant (East-3, and North-3) but were not.

Additional Training and Counseling

FDCRs and AARs were audited to assess whether supervisors consistently determined whether additional training or counseling was warranted. Of the 140 cases audited during the Q2 2016 period the command review indicated in 12 cases (8%) that the at least one involved member should receive additional training or counseling. Of the 12 cases where additional training and counseling was warranted, 3 cases were from Central Precinct, 4 cases from East Precinct, 1 case from North Precinct, 1 case from DVD, 1 case from Canine, 1 from TOD, and 1 from Transit.[55] [56]

[55] DOJ Agreement: 75h
[56] DOJ Agreement: 75g