Portland Police Bureau

2016 Q3 Force Audit Report

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Strategic Services Division

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Force Audit Report

Q3 2016 (July – September)

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 Portland Police Bureau (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 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 (Employee Information System). PPB is currently developing in-service training for supervisors for better review of officer use of force reporting. This training should reduce the need for corrective action.
- Additional reminders from command to officers continuing to emphasize the need to request and, if possible, to wait for cover officers to arrive, as this is one factor that may assist in lowering the need to use force.
- The audit identified issues with officer use of the Taser X2 ECW (Electronic Control Weapon). Specifically around accurately reporting cycles applied. This issue is currently being addressed at the 2016 in-service.
- The audit identified a gap in documenting corrective action for training deficiencies, policy deficiencies, or poor tactical decisions by the officer, identified in the CHO (Chief's office)-level of the AAR review, in EIS. The PPB is currently in the process of correcting this issue - this will be addressed in supervisor in-service training 2017.
- Auditors recommend specific direction for officers regarding reporting of ECW use and the practicality of hands-on control.

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Force and Subject Resistance

Overview

Ninety-eight cases were audited during Q3 (July-September) 2016. Of the 98 After Action Reports (AAR) audited there were 11 complaint of injury (COI) cases, and 3 Other (Administrative, Alleged Excessive Force) in which no FDCR (Force Data Collection Report)-level force was used. The 98 cases contained 153 officer-subject interactions.[1] One hundred forty-eight officers utilized 176 FDCR-level applications of force. This resulted in 1.8 force applications per force case and 1.2 force applications utilized per officer. These rates are consistent with Q1 and Q2 2016.

Summary of Audited Cases

98 Cases Audited	**84 FDCR-Level Cases Audited**
	11 Complaint of Injury and In-Custody Injury Cases Audited
	3 Other (Administrative, Alleged Excessive Force)

153 Officer-Subject Interactions	**129 FDCRs (FDCR-Level Officer-Subject Interactions**
	24 Complaint of Injury Officer-Subject Interactions

	176 Applications of FDCR-Level Force

Summary of Force Options Applied

Force Options	Total Applications
Baton	1
Control Holds w/Injury	6
K9 Bite	1
Less Lethal Bean Bag	1
Pepper Spray	11
PFA*	3
Strikes/Kicks	21
Takedown	82
ECW	50
Total	176

[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.

**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.*

Use of Force Precinct and Shift by Case

	A	B	C	D	E	Specialty	Total
Central	12	1	4	0	6	0	**23**
East	8	2	10	4	11	0	**35**
North	8	1	5	0	5	0	**19**
SERT	0	0	0	0	0	1	**1**
TOD	1	0	1	0	0	0	**2**
Traffic	0	0	1	0	0	0	**1**
Transit	1	1	1	0	0	0	**3**
Total	**30**	**5**	**22**	**4**	**22**	**1**	**84**

Force Applications and Officer Precinct/Division

Total Applications of Force for Each Precinct/Division

Precinct	Baton	Less Lethal Bean Bag	Control Holds w/Injury	Strikes/ Kicks	K9	Pepper Spray	PFA	Takedown	ECW	Total
Central	0	0	3	2	0	2	0	21	13	41
East	1	0	3	10	0	4	3	36	26	83
North	0	1	0	8	0	4	0	20	6	39
SERT	0	0	0	0	1	0	0	0	3	4
TOD	0	0	0	0	0	0	0	1	2	3
Traffic	0	0	0	1	0	0	0	1	0	2
Transit	0	0	0	0	0	1	0	3	0	4
Total	**1**	**1**	**6**	**21**	**1**	**11**	**3**	**82**	**50**	**176**

Patrol precincts used more force applications than the other divisions of the Portland Police Bureau (PPB). East Precinct used the greatest number of force applications, followed by Central Precinct and North Precinct. This distribution of the application of force is similar to last quarter's distribution.

Rate of Total Force Applications for Each Precinct

	Number of Cases Audited	Rate of Force Applications
Central	23	1.8
East	35	2.4
North	19	2.1
SERT	1	4.0
TOD	2	1.5
Traffic	1	2.0
Transit	3	1.3
Total	**84**	

When comparing the ratio of the 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 (1.8) compared to East and North Precincts (East-2.4 and North-2.1). The application rate of force applied for all 3 patrol precincts is similar to last quarter.

Rate of Type of Force Applications for Patrol Precincts

	Central Precinct		East Precinct		North Precinct	
Baton	0	0%	1	1%	0	0%
Less Lethal Bean Bag	0	0%	0	0%	1	3%
Control Holds w/Injury	3	7%	3	4%	0	0%
Strikes/Kicks	2	5%	10	12%	8	21%
K9	0	0%	0	0%	0	0%
Pepper Spray	2	5%	4	5%	4	10%
PFA	0	0%	3	4%	0	0%
Takedown	21	51%	36	43%	20	51%
ECW	13	32%	26	31%	6	15%
Total	**41**	**100%**	**83**	**100%**	**39**	**100%**

When comparing the specific force options used for each division, the analysts found that in this quarter, again, East Precinct officers used their ECWs (Electronic Control Weapons) more than twice as many times as Central Precinct officers, and over 4 times more often than their North Precinct counterparts. Most notably, **76% of East Precinct's ECW applications were applied to subjects who were armed**. See *Officer-Subject Interactions with Armed Subjects* section for more information.

When the rate of ECW use is compared across patrol precincts, officers at East Precinct and Central precinct use their ECWs at a similar rate. This deviates from the rate of ECW use per precinct identified in Q1 and Q2 2016 Force Audit Reports; where the average rate of ECW use was 12% and 9%, respectively, and where the rate of ECW use at East was approximately twice the rate of ECW use at Central and North Precincts.

East Precinct officers used the PFA force option in conjunction with another FDCR-level option more than the other two patrol precincts due to a greater number of officer-subject interactions involving an armed subject (East-3). In 1 case, 2 officers pointed their firearms at a single subject who was armed with a firearm, and in the second case the subject was armed with a knife or bladed weapon. This is similar to Q2 2016 where East Precinct used the PFA force option more frequently than other divisions.

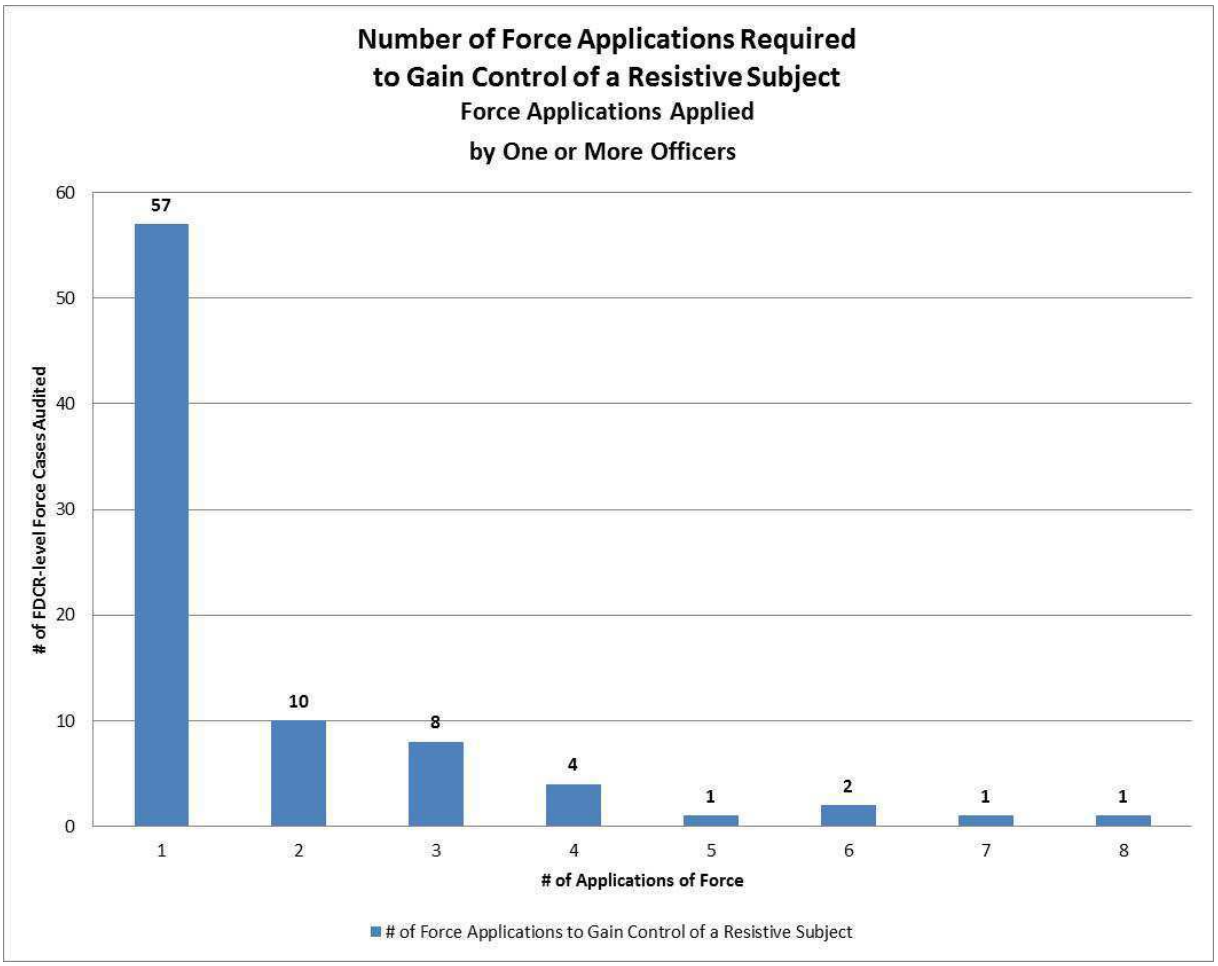
Force Applications and Subject Resistance

Subject Resistance and Force Option Applied

	Baton	Less Lethal Bean Bag	Control Holds w/Injury	Strikes/ Kicks	K9	Pepper Spray	PFA	Takedown	ECW	Total
Passive	0	0	0	0	0	0	0	2	0	2
Active	1	0	4	7	0	6	2	53	22	95
Threat of Assaultive Resistance	0	1	0	7	0	2	0	13	14	37
Assaultive	0	0	2	6	1	3	0	14	9	35
Threat of Immediate Deadly Force	0	0	0	1	0	0	1	0	1	3
Deadly	0	0	0	0	0	0	0	0	4	4
Total	**1**	**1**	**6**	**21**	**1**	**11**	**3**	**82**	**50**	**176**

The Department of Justice's (DOJ) Settlement Agreement (SA) requires that officers consistently choose force options reasonably calculated to establish and maintain control with the least amount of appropriate force when compared to the subject's resistance. Two officers indicated in their reports (1%) that they used force against a subject who was engaged in passive resistance (TOD-1, East/A-1). In the TOD case, an officer performed a traffic stop, the subject of which was impeding a lawful objective with his passive resistance. The officer performed a takedown by removing the subject from the car, and the event was found to be in policy. In the East Precinct case, a cover officer applied a takedown to the subject of a traffic stop who was not impeding a lawful objective with his passive resistance. This officer's actions were found out of policy and he was re-assigned pending an IA investigation. [2] [3] [4] See *Determination of Whether the Force was In or Out of Policy* section for further information.

Generally, PPB officers use only one force application to resolve a force event and to take a resistive subject into custody. According to the data below, 57 of 84 force events were resolved with a single application of force by the involved officers. Furthermore, 75 of 84 force events audited this quarter were resolved with three applications of force or less; leaving just a few outlying cases (10%) that were resolved with four or more uses of force.



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

Subject Resistance and Progression of Force Event

***Aggressive Resistance : Threat of Assaultive Resistance, Assaultive, Threat of Deadly Force, Deadly Force**

	Passive	Active	Threat of Assaultive Resistance	Assaultive	Threat of Immediate Deadly Force	Deadly	Total
1st Application	2	54	26	21	3	1	**107**
2nd Application	0	13	5	8	0	1	**27**
3rd Application	0	9	4	4	0	1	**18**
4th Application	0	5	1	2	0	1	**9**
5th Application	0	4	1	0	0	0	**5**
6th Application	0	4	0	0	0	0	**4**
7th Application	0	2	0	0	0	0	**2**
8th Application	0	4	0	0	0	0	**4**
Total	**2**	**95**	**37**	**35**	**3**	**4**	**176**

Anecdotally, we expect that a force event will coincide with a subject's display of active resistance. When the officer applies force, the subject resistance will end (effectively ending the force event), stay the same, or escalate. If subject resistance escalates, we would expect that officers will reassess the situation and apply additional force, as necessary, until the officer can gain control and take the subject in to custody.

For the first application of force, officers described subject's resistance as active (50%) or aggressive (46%). For the second application of force, over 50% of the subject resistance was described as aggressive. For the third application of force, subject resistance was described as active (50%) and aggressive (50%) By the fourth application of force, officers described subject resistance more regularly as active (55%). In the sixth, seventh and eighth applications, subject resistance was described exclusively, as active.

These findings indicate two things; (1) that officers do not use force against subjects that have stopped resisting arrest and, (2) that when officers use multiple force applications, subject resistance spikes to aggressive then decreases to active and levels off before officers eventually take the subject into custody.[5]

Unarmed Subject Resistance and Force Option Applied

When considering unarmed subjects, takedowns were most regularly applied as the first type of force in an event (74%) and subject resistance was most often described as active for the first application of force (54%). When we adopt the 4 category force model, we expect to be able to discern officer application of an arm-bar takedown from officers gently setting a subject on the ground (a discernment for which our current model does not allow). When officers applied multiple force options, takedowns were, again, most regularly chosen as the second force option applied (40%), followed closely by ECW (20%).

Armed Subject Resistance and Force Option applied

When considering armed subjects, ECWs were most regularly applied as the first type of force in an event (70%) and continued to be the most regularly applied control tool through the first 6 applications

[5] DOJ Agreement: 74a vi

of force. This is consistent our expectations of officer engagement with an armed subject. It would be unreasonable and unlikely than an officer would regularly choose a takedown to control an armed subject because that approach would expose the officer to a higher likelihood of injury or death.

The subject-officer interactions that resulted in force in East Precinct were more likely to involve an armed subject (East-17 armed subject-officer interactions compared to Central-8 armed subject-officer interactions, North-5 armed subject-officer interactions). Moreover, during this audit period, 4 officers at East Precinct faced 1 subject who was armed with a firearm, while officers at Central and North did not have any officer-subject interactions with subjects carrying a firearm. This is similar to last quarter. The Force Inspector will present this information to the East Precinct command staff for them to disseminate to the officers in the precinct.

Integrity of the Data

Integrity of the Data used to substantiate Settlement Agreement Sections 74aiii, 74avi, 74c iv, and 74c viii Findings

# of Narrative Reports that Described the Subject's Resistance	# of Required FDCRs Written	# of Applications of Force (FDCR) or Narrative	Complete and Accurate Account of Force Decision Making
176 (100%)	124 (96%)	162 (92%)	127 (98%)

One-hundred percent of the narrative reports that were audited during this period documented the subject's resistance. This is similar to our findings from Q2 2016.

The FDCRs that officers submitted captured 162 of the 176 applications of force. With takedowns the most likely to be omitted followed by control holds with injury. Given the lack of clarity surrounding the definitions of these force types, it is not surprising that they were the two types of force that were most often omitted. We expect this to improve with the release of the updated 1010.00 directive in 2017 that will provide clearer definitions of force types. The definition of takedown is currently being discussed during in-service 2016.

The audit methodology measured whether officer's included a detailed description of the force used, to include descriptive information regarding the use of any weapon by evaluating the accuracy of force options documented on the officer's FDCR and whether any officers narratives were a complete and accurate account of the force decision making. The results demonstrate that officers are more likely to correctly document the force used in their narrative reports rather than using the checkboxes on their FDCRs. One hundred of 129 FDCRs (78%) had the correct force options marked. Twenty-nine FDCRs did not have the correct force options marked.[6]

Force Applied and Supervisor's Review

All reporting requirements for the sergeant specific to analyzing the officer's use of force improved significantly compared to the Q1 and Q2 2016 Force Audit results.

In 91% of cases audited the sergeant indicated that the officer used the least amount of appropriate force when engaging with the subject. Sergeants who did not include this information were distributed

[6] DOJ Agreement: 74c iv

among the following precincts (Central-2, East-4, TOD-1, and Transit-1). This is an improvement over last quarter's findings, specifically among reporting by sergeants assigned to specialty units.

In 98% of cases the investigating sergeant included a description of the level of resistance encountered by the officer that led to each separate use of force and, if applicable, injury. The single case where the sergeant failed to include this information was a Transit case investigated by a non-PPB sergeant.

In 100% of cases requiring it, the sergeant determined that there was legal justification for the original stop and/or detention.

In this quarter, analysts had the opportunity to identify discrepancies between officer reporting and sergeant reporting regarding the force options documented, the subject's resistance, and the subject's injury. In 71% of cases audited the force options documented by the officers on their FDCRs were consistent with the force options documented in the investigating sergeant's AAR - distributed as follows; Central-3, East-6, North-3, and Transit-1.

For this audit period, there were no discrepancies between with the subject resistance documented by the officers and the subject resistance documented by the supervisor in the AAR.

Additionally, in 90% of cases audited, the subject injuries documented by the officers were consistent with the subject injuries documented in the AAR. See *Subject Injury Documentation* section for additional details.[7]

The audit found that the when reporting requirements for the sergeant's AAR were not met - specifically those needed to analyze the officer's use of force - the deficit was not addressed during the command review, but was most often addressed through an Audit Findings Report.

Decision Point Description

To answer the question of whether or not officer's use decision point analysis, we assess their reporting in four different areas (1) documentation of the subject's resistance prior to the application of force, (2) documentation of alternative force options considered, (3) documentation of the reason for the initial police presence and (4) documentation of de-escalation techniques and their effectiveness.

Documentation of Subject's Resistance Prior to the Application of Force

In 100% of the cases, officers met the necessary reporting requirement of documenting the subject's resistance prior to the application of force. This is an improvement from Q2 2016 where 2 (1.5%) officers from East Precinct failed to include this information. [8]

In 98% of cases reviewed, the sergeant documented the subject's resistance prior to the application of force. The sergeant did not include the level of resistance encountered by the officer that led to each separate use of force, and if applicable injury, in 1 force case audited (Transit/A-1). An Audit Findings Report was produced noting the reporting deficit; however, the sergeant does not work for PPB and does not know the reporting requirements. The results are similar to Q2 2016, in which all sergeants included the level of resistance encountered by the officer that led to each separate use of force. This is a significant improvement in this reporting requirement from Q1 2016 in which 12% of sergeants did not

[7] DOJ Agreement: 74a vi
[8] DOJ Agreement: 74c vii

include the level of resistance encountered by the officer that led to each separate use of force, and if applicable, injury. [9]

Documentation of Alternative Force Options Considered

Seventy-six percent of officers met the necessary reporting requirement of providing alternative force options that they considered at the time of the use of force. This is a tremendous improvement over Q2 2016, where officers included a description of other force options that were considered in only 63% of their reports.

Reports from officers on Shift A made up almost half of the reports that were missing this reporting requirement for this auditing period. With regard to Precinct, officers in East Precinct were most deficient on this reporting requirement, submitting 20% of the reports that were deficient in this area. We think that this improvement is related to clear instruction and coaching by supervisors. We expect continued improvement in this metric with the introduction of new use of force reporting forms in 2017. The revised use of force report will prompt officers for the inclusion of required details.

The sergeant did not include a description of other force options considered by the officer in their review in 13 force cases (15%) audited (North/A-2, North/E-2, North/B-1, North/C-1, Central/A-1, East/A-1, East/B-1, East/C-1, East/D-1, Traffic/C-1, Transit/B-1). An Audit Findings Report was produced and an EIS entry made documenting the discussion with the sergeant's supervisor in 7 cases. An Audit Findings Report was produced, but no EIS entry was made in 2 cases - 1 case involved a sergeant who was from another agency. The sergeant's supervisor addressed the deficit in their review and made an EIS entry documenting the discussion in 4 cases. The Q1 2016 Force Audit found that 70% of supervisor reviews did not include a description of other force options considered by the officer in their review.

Documentation of the Reason for the Initial Police Presence

One-hundred percent of officer narratives audited included the reason for their initial police presence. This reporting requirement has consistently improved since the first Force Audit report (Q1 2016) when 4 officers failed to include this information and in Q2 2016 - 1 officer failed to include this information in their narrative.

One-hundred percent of all force cases audited, the sergeant's review indicated the reason for the initial police presence. This is an improvement over Q2 2016 in which 1 sergeant failed to include the reason for the initial police presence in their review. [10]

Documentation of De-escalation Techniques and their Effectiveness

One hundred forty-three (93%) officers documented in their narrative reports that they used de-escalation techniques, or documented why de-escalation techniques were not appropriate. This reporting requirement has been steadily improving since the first Force Audit Report (Q1 2016 - 77%, Q2 2016 - 83%). Five officers did not include an explanation of why de-escalation techniques were not used (East/A-2, East/E-1, East/C-1, Transit/B-1). Audit Findings Reports were produced for two officers. At the time of this report, a response has not been received. The issue was addressed for the third officer in the command review. The findings and debriefing with the officer were noted in the officer's EIS. The case was referred to the Internal Affairs Division (IAD) and the officer was reassigned pending the outcome of the investigation. For the final two officers, the issue was addressed in the command

[9] DOJ Agreement: 75b
[10] DOJ Agreement: 74c vi

review, the officers were counseled, supplemental reports were submitted, and an EIS entry noting the discussion was made for each officer.

One-hundred percent of officers who documented in their narrative reports that they used de-escalation techniques, also included whether they were effective, or not.

When the officer included de-escalation techniques the sergeant included a description of the de-escalation techniques as part of their decision-point approach to analyzing the use of force in all but 1 use of force AAR audited (East/A-1). The CHO identified this reporting error and sent an email to the RU (Reporting Unit) Manager. An EIS entry was made by the sergeant's supervisor documenting the discussion of reporting requirements. If the officer did not include de-escalation techniques in their narrative, the sergeant included the reason why in all cases where de-escalation techniques were not used. This indicates attentive review of officer reports by sergeants. The sergeant included an explanation of if the de-escalation techniques were effective in all but 2 use of force AARs audited (East/A-2). Audit Findings Reports were produced for each case. EIS entries were made for both sergeants by their supervisor documenting the discussion regarding reporting requirements.[11] [12] [13] [14] [15]

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 an ECW (30),
> (2) The number of ECW cycles documented by the officer/supervisor in the officer's narrative report and the AAR (officer: 54 cycles, supervisor: 60 cycles), and
> (3) The number of ECW cycles indicated by the ECW download report (58 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 Q3 2016 there were 30 cases in which an officer applied an ECW to a subject. Based on the ECW download reports, 30 officers applied 58 cycles of an ECW to 25 subjects. This results in an average ECW rate of 1.93 cycles per officer and 2.32 cycles per subject.

[11] DOJ Agreement: 75g
[12] DOJ Agreement: 74c iii
[13] DOJ Agreement: 75d
[14] DOJ Agreement: 75f
[15] DOJ Agreement: 74c vii

Precinct /Unit	1 cycle	2 cycles	3 cycles	4 cycles	5 cycles	6 cycles	No Download Document Found	Download Document Corrupted
Central	2	3	1	0	1	0	0	0
East	5	2	3	1	0	1	2	1
North	3	1	0	0	0	0	0	0
SERT	0	0	1	1	0	0	0	0
TOD	2	0	0	0	0	0	0	0

Reporting Discrepancies - Number of Cycles and ECW Download Document

In 2 cases (East/D-1, East/E-1) no ECW download document was found. In the first case, the officer and supervisor reported that 1 cycle was used. In the second case, the officer and supervisor reported that 1 cycle was used. For the first case, the analysts issued an audit findings report for the missing ECW download, issued 7/14/16, and the ECW download was uploaded on 7/24/16. For the second case, the analysts issued an audit findings report for the missing ECW download, issued 7/25/16, and the ECW download was uploaded on 8/3/16.

In 1 case (East/C) the ECW download document was found, but the data was corrupted. The officer and supervisor reported that 1 cycle was used.

Regarding the number of cycles deployed, the audit found when comparing the officer's narrative, AAR, and the ECW download document, all reports were consistent in 21 cases reviewed. There were 7 cases in which there were inconsistencies between the officer's narrative, the ECW download report and/or the AAR. The reason for the discrepancy was determined and resolved appropriately, i.e. discipline, EIS entry, etc. in all 7 cases.

ECW Reasonableness and Justification

That the officer evaluated the reasonableness, need and justification for each ECW cycle used was not found documented in 5 of the 30 (17%) officer narratives audited (Central-2, East-2, SERT-1). When an officer's narrative did not indicate the reasonableness, need and the justification for each ECW cycle, a supervisor addressed and corrected the issue in 5 instances.[16]

Hands-on Control and Documentation of Environmental Factors

Officer's documented if an attempt to use hands-on control during an ECW cycle was practical or not for 36 of the 58 ECW cycles documented (62%). In 20 of 58 documented ECW cycles, whether an attempt to use hands-on control during an ECW cycle was practical or not was not found (East/E-11, North/C-2, Central/C-2, East/A-2, Central/A-1, East/C-1, SERT-1).

Multiple factors can influence whether an officer decides hands-on control during an ECW cycle is practical, or not. The audit identified the following most common factors:

- the amount and type of resistance the person against whom the ECW was used offered - 52 cycles;
- the number of officers present at the time the ECW was deployed - 41 cycles;
- the severity of the underlying reason for attempting control of the person - 40 cycles;

[16] DOJ Agreement: 74b ii

- other factors documented by the officer as influencing the event, decision making and outcome - 35 cycles;
- the obvious presence of weapons - 25 cycles;
- environmental factors such as physical barriers and/or terrain - 24 cycles;
- the reasonable suspicion the person was armed with a weapon - 21 cycles. [17]

ECW Pain Compliance and Rational Response

Eight ECW cycles were deployed in drive stun mode. Three of the 8 ECW cycles were used on a subject whose mental health issues were known prior to the use of force (SERT (Special Emergency Reaction Team)-2, East-1). The investigating supervisor found that the 3 ECW cycles were used to avoid using a higher level of force.[18]

Reporting Requirements – Officer, Sergeant, Subject, and Witnesses

Three reporting requirements were used to assess whether officer narrative reports were sufficient to allow supervisors to accurately evaluate the quality of the officer's decision making and performance: (1) reports included a detailed description of the unique characteristics of the event using common everyday language, (2) reports were a complete and accurate account of the force decision making, and (3) reports included the reason for the initial police presence.

Officer's Narrative Included a Detailed Description of the Unique Characteristics of the Event

One officer's narrative did not include a detailed description of the unique characteristics of the event (East/A-1). The officer's report did not include when the subject's mental health issues were discovered. In addition the officer's report was not clear as to whether a warning was given prior to the use of an ECW. The officer's report did not include a description of attempting to locate witnesses, the subject's injuries, and treatment received. The officer was counseled on the reporting discrepancies, a supplemental report was submitted correcting the issues, and an EIS entry was made for the officer documenting the counseling. This is a significant improvement over the Q2 2016 Force Audit Report in which 4 officer reports were found lacking a detailed description of the unique characteristics of the event.

Officer's Narrative was a Complete and Accurate Account of the Force Decision Making

The audit found 2 officer narratives that were not a complete and accurate account of the force decision making (East/A-2). In the first narrative, the officer did not clearly document a force option used. The issue was not addressed in the AAR. An Audit Findings Report was submitted. At the time of this report, a response has not been received. The officer has since retired from PPB. The second narrative did not indicate a specific reason for each force option used. This issue was addressed by the officer's supervisor and the use of force was found out of policy. The findings and debriefing with the officer were noted in the officer's EIS. The case was referred to the Internal Affairs Division (IAD) and the officer was reassigned pending the outcome of the investigation. [19] [20]

[17] DOJ Agreement: 74b iii
[18] DOJ Agreement: 74b iv
[19] DOJ Agreement: 74c iv
[20] DOJ Agreement: 74c vii

Sergeant's Evaluate Whether Officer's Reporting was a Complete and Accurate Account of the Force Decision Making

In 82% of AARs audited officer reporting was found to be a complete and accurate account of the force decision making by investigating sergeants. In 6 cases (7%) the sergeant found that the officers' reports were not complete and accurate accounts of the force decision making (Central-2, East-3, North-1). In these cases, reports were sent back to officers for clarification or officers were instructed to submit supplemental reports with additional details.[21]

This finding has decreased from the Q2 2016 audit finding report (78%) and is likely due to increased scrutiny of officer reports by investigating sergeants.

Officer Narratives Include the Reason for the Initial Police Presence

One-hundred percent of officer narratives audited included the reason for their initial police presence. This is an improvement over Q2 2016 in which 1 officer did not include this information in their narrative.[22]

Sergeant's Evaluate Whether Officer's Reporting Included the Initial Police Presence

Sergeant's included the reason for the initial police presence in their AARs in 100% of the cases audited during this period.

Witness Documentation

Officer Witnesses

In 2 cases, officer's did not include a general description of force they observed another officer apply (Central-1, North-1). This reporting deficiency was not documented in the officer's EIS discussion tracker. In the case from North an officer did not provide details of the force that another officer used (strikes/kicks and takedown). Their reporting errors were not documented in the EIS entry made by the investigating sergeant. [23]

Officer Documentation of Civilian Witnesses

Thirty officers (20%) did not include in their reports that they made efforts to document witness observations. This is a significant improvement over the Q2 2016 Force Audit results in which 47% of officer narratives did not include that they made an effort to document witness observations. When an officer did not include this reporting requirement in their report, the officer also did not include an explanation of circumstances that prevented them from identifying witnesses or obtaining contact information in 29 narrative reports:

- The reporting deficit was noted by the CHO, an email sent to the RU Manager and an EIS entry made documenting the discussion with the officer for 1 narrative report.
- For 7 narrative reports, the deficiency was noted by the CHO and an email was sent to the RU Manager. However, an EIS entry for the officer was not found.
- An Audit Findings Report was produced for 14 of the officers where the deficit was not addressed in the AAR. In response to this, supervisors made EIS entries for 5 officers documenting their discussion regarding reporting requirements. However, neither a response to

[21] DOJ Agreement: 75b
[22] DOJ Agreement: 74c ii
[23] DOJ Agreement: 74c x

the Audit Findings Report, nor an EIS entry was found for 9 officers whose narrative reports did not include that they made efforts to document witness observations.

- For 7 officers, a supervisor (other than the CHO) noted the deficit and documented the discussion in EIS.[24]

Sergeant Documentation of Civilian Witnesses

In 2 cases (2%) there were civilian witnesses but they were not listed on the AAR. This is similar with our findings from the Q2 2016 audit report, where the sergeant did not document witnesses in 1% of cases audited. In the first case, from North/E, the sergeant provided an explanation that, due to the hostility of the crowd, it was too dangerous to attempt photographing the subjects or to interview witnesses. In the second case, from East/A, the sergeant provided no explanation as to why witnesses to the event were not listed in the AAR. This reporting error was identified by the CHO's office but it is unclear whether or not the CHO notified the RU manager and no EIS entry was made.

In 61 cases witnesses were present, in 2 of these cases (3%) the sergeant did not include the witnesses account of the event (Central/A-1, North/E-1) In the case from Central, the sergeant provided an explanation. In the case from North, the investigating sergeant listed two witnesses on the AAR, but only interviewed one of the witnesses and did not explain why the other witness was not interviewed. The analysts issued an Audit Findings Report for reporting errors related to this case and the sergeant's supervisor made an EIS entry documenting their subsequent discussion regarding documentation of witnesses.

In cases where witnesses were identified and listed in the AAR, the sergeant generally captured both the name of the witness and a manner of contacting the witness at a later date. In 3 cases, the sergeant captured the name of the witness only and did not document a manner of contacting the witness at a later time (Central/A-2, Central/C-1). In all 3 cases the sergeant did not explain the reason that the information was not recorded. In all 3 cases the sergeant's supervisor made an EIS entry documenting this error after receiving an Audit Findings Report regarding the reporting deficiency.

For audit findings related to subject injury documentation see the *Subject Injury Documentation* section.

Timeliness of Reporting

FDCR Timeliness

For this period 5 officers failed to complete an FDCR for the event (Central/C-1, East/B-1, East/E-1, North/A-1, North/E-1). This is similar to previous quarters. After receiving instruction from their chain of command regarding the missing FDCRs, 4 of missing FDCRs were submitted. This is tremendous improvement over previous quarters and suggests that the accountability mechanism created by the audit report findings process is working.

When officers completed FDCRs, only 4 were not completed by the end of the officer's shift.

- (FDCR 1) the FDCR date in REGJIN was a day after the event occurred. It is possible that the officer entered the incorrect date while filing out the FDCR.

[24] DOJ Agreement: 74c xi

- (FDCR 2) In the second case, the date of the FDCR is 27 days post event. The CHO had determined during their review that the officer had failed to submit an FDCR.
- (FDCR 3) and (FDCR 4) were FDCRs that were completed by the same officer in North Precinct for one case. In this case, the first use of force occurred at 9am and then a second use of force at 3pm. Both uses of force involved the same subject. But, the officer did not submit any of their FDCRs for the event until the next day around 11am. It is unlikely that this was a data entry error, as the officer submitted additional reports on the day of the event. There was no explanation for the delay.[25]

After Action Report (AAR) and Review Timeliness

Ninety-one percent of the cases audited this quarter met the required timeline for review at all levels of command. Analysts identified 8 cases which did not meet the timeline for review at either a single or multiple stages during the review process (Central/A-2, Central/C-1, East/D-1, North/A-1, North/E-3). Seven of the 8 cases that missed a review timeline were accompanied by an explanation for their delay. Only 1 case audited during this time period missed a deadline for review without explanation (East Precinct - Shift D).

Four of the 8 AARs that did not meet the timelines for review were from North Precinct. A RU Manager at North Precinct was the reason for the failed timelines being met. This was discovered and the RU Manager was directed from the CHO to complete the AARs as soon as possible to comply with the timelines. The Force Inspector was made aware that the RU Manager was pending retirement and leaving the PPB in October. The Force Inspector made admonishments that if the RU Manager was still in place and did not retire; an official recommendation would be made to the IPR (Independent Police Review) of referral of directive violation.

Fifteen AAR timelines (in 8 cases) were missed during the Q3 2016 audit period, for a missed timelines rate of 3.4% (13/382). This rate of missed timelines is greater than both Q2 2016 and Q1 2016 where missed timeline rates were 2.3% and 2.6% respectively. [26]

In/Out of Policy

Supervisor Evaluation of the Evidence

For additional audit reporting results, please see *Reporting Requirements – Officer, Sergeant, Subject, and Witnesses.*

General Description of the Force an Officer Observed Another Officer Apply

During this reporting period there were 31 cases where there was only one officer who used force, and subsequently there was no general description of the force an officer observed another officer apply. In all applicable cases (53), the sergeant documented the force an officer observed another officer apply.

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.

[25] DOJ Agreement: 74c i
[26] DOJ Agreement: 75a

Missing FDCR

There were 5 cases (Central/C-1, East/B-1, East/E-1, North/A-1, North/E-1) where officers did not submit FDCRs and sergeant's failed to identify those missing FDCRs in their review. In the 2 cases from North, the sergeant's received EIS entries addressing this deficiency. For the remaining precincts, the sergeant's received no EIS entry at all, or the EIS entry they received did not address this reporting deficiency.[27]

Evidence – Witnesses

See *Witness Documentation* section for further information.

Evidence – Subject Statement

See *Subject Injuries and Treatment Received* section for information.

Evidence – Photos/Video

In 7 cases (8%) (North/E-2, North/C-1, North/A-1, East/B-1, East/C-1, Transit/C-1) photos were not found in DIMS (Digital Image Management System). In 1 case the sergeant acknowledged that they did not take photos; explaining that the hostility of the surrounding crowd made it too dangerous to take photos of the scene. Of the other 6 cases, an EIS entry documenting this deficiency was made for the sergeant in 1 case. For the remaining 5 cases, either no EIS entry was made at all or the EIS entry that was created did not address this reporting deficiency.

Evaluate the Weight of the Evidence - Conclusion

In 78 cases (92%) supervisors measured the evidence of the officers account versus the evidence of the subject's and witnesses accounts and determined whether the evidence supporting the officer's account was greater than any other alternative account. In 6 cases analysts determined that it would not have been possible to measure the evidence of the officers account versus the evidence of the subject's and witness accounts to determine whether the evidence supporting the officer's account was greater than any other alternative account because evidence was not present and thus could not be evaluated (East-3, Central-1, North-1, Transit-1). This is similar with our findings from Q2 2016, where 4% of audited cases were missing evidence that precluded this evaluation by supervisors. [28] [29]

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

The sergeant did not address in their review if the officers' actions were consistent with PPB policy, or not in 1 case involving 2 officers (North/A). An Audit Findings Report was produced and an EIS entry was made by the sergeant's supervisor addressing the discussion.

The audit found that when the sergeant and lieutenant identified the actions of an officer out of policy, the RU manager and CHO agreed. However, both the RU manager and CHO identified additional officers whose actions were determined to be out of policy. All 4 levels of review (sergeant, lieutenant, RU manager, and CHO) found the actions of 4 officers out of PPB policy (Central/A-2, East/A-1, East/D-1). The RU manager identified the actions of 2 additional officers out of policy (Traffic/C-2); however the CHO did not find the officers' actions out of policy. The CHO identified the actions of 2 additional officers out of policy (East/A-1, TOD/A-1).

[27] DOJ Agreement: 75b
[28] DOJ Agreement: 75c
[29] DOJ Agreement: 77a

- (Case 1) All levels of command found the officers' actions out of policy of Directive 1051.00 (Electronic Control Weapon System). The officer was debriefed by their supervisor. The supervisor reviewed the Directive with the officer specifically covering the definition of active aggression and the prohibitions for when an ECW can be deployed. The command review did not find the officers' actions consistent with best practices or the DOJ Settlement Agreement, as well. An EIS entry was made by the officer's supervisor documenting their debriefing and that the use of force was found out of policy. No further counseling or training was needed.
- (Case 2) All levels of command found the actions of 2 involved officers out of policy. The first officer was out of policy of Directive 870.25 (Temporary Holding Rooms) and a precinct SOP. The Directive and SOP were reviewed with the officer by the officer's supervisor. The command review did not find the officers' actions consistent with best practices or the DOJ Settlement Agreement, as well. An EIS entry was made by the officer's supervisor documenting their debriefing and that the actions of the officer were found out of policy. The second officer was out of policy of Directive 660.10 (Property and Evidence Procedure). The Directive was reviewed with the officer by the officer's supervisor. The command review did not find the officers' actions consistent with best practices or the DOJ Settlement Agreement, as well. An EIS entry was made by the officer's supervisor documenting their debriefing and that the actions of the officer were found out of policy. No further counseling, or training was needed.
- (Case 3) All levels of command found the actions of the officer out of policy of Directives 1010.00 (Use of Force), 310.40 (Courtesy), 315.30 (Satisfactory Performance), and 940.00 (After Action Reports). The officer was counseled by their supervisor and the case was referred to the Internal Affairs Division (IAD). The command review did not find the officers' actions consistent with best practices or the DOJ Settlement Agreement, as well. The officer's supervisor made an EIS entry documenting the use of force, out of policy finding and discussion. No further corrective action has been taken pending the outcome of the investigation.
- (Case 4) The RU manager found the actions of 2 officers out of policy of a Division SOP. The involved officers did not re-handcuff a subject immediately after conducting a field sobriety test. The officer's actions were also found inconsistent with best practices, as well. The officers were de-briefed on the SOP. An EIS entry was made for each officer that included the finding and discussion. No further counseling, or training was needed.
- (Case 5) The CHO found the actions of 1 officer out of policy of Directive 1051.00 (Electronic Control Weapon System) for failing to give a warning prior to deploying an ECW. The officers' actions were found inconsistent with the Settlement Agreement, as well. The officer was de-briefed and an EIS entry was made documenting the discussion. No further counseling or training was needed.
- (Case 6) The CHO found the actions of 1 officer out of policy of Directive 1051.00 (Electronic Control Weapon System) for failing to give a warning prior to deploying an ECW. The officers' actions were found inconsistent with the Settlement Agreement and best practices, as well. The officer was de-briefed and an EIS entry was made documenting the discussion. No further counseling or training was needed.[30]

Modified Findings

The audit identified cases where someone in the command review requested additional investigation when there may be additional relevant evidence that may assist in resolving inconsistencies or improve the reliability or credibility of the findings, but did not indicate if they modified their findings, or documented the modifications based on the new evidence. Sergeants assigned to East (East/A-2, East/C-

[30] DOJ Agreement: 75e

1, East/E-1) were the least likely to document if they modified their findings or not. Central (Central/A-1, Central/C-2) and North (North/A-1, North/B-1, North/C-1) sergeants did not document if they modified their findings or not for 3 cases. Lieutenants assigned to East (East/C-2, East/A-1, East/E-1) were the least likely to document if they modified their findings or not. North Precinct lieutenants did not document if they modified their findings, or not after requesting additional investigation in 3 cases (North/A-1, North/C-1, North/E-1). Central Precinct lieutenants did not include if they modified their findings, or not in 2 cases (Central/A-1, Central/C-1). RU Managers did not include whether they modified their findings or not in 3 cases distributed evenly across day, afternoon, and night shifts for each Patrol Precinct (Central-3, East-3, North-3). The CHO did not indicate whether they modified their findings, or not in 11 cases in which additional investigation was requested when there may have been additional relevant evidence that may assist in resolving inconsistencies, or improve the reliability or credibility of the findings.[31]

Mental Health

Thirty-three of the 98 cases (34%) audited involved a least one subject with either perceived or actual mental health issues. During the Q3 2016 auditing period officer-subject interactions involving a subject with perceived or actual mental health issues accounted for 35% of overall officer-subject interactions. [32]

The Complaint of Injury cases were excluded to determine in use of force cases only: (1) whether officer's reports described the mental health information available to them and (2) the role of that information in their decision making.

Forty-six officers indicated in their reports that they knew of the subject's mental health issues, or that the subject did not have mental health issues. Twenty-seven officers indicated that they had knowledge of the subject's mental health issue prior to using force. Six of those officers did not include in their reports the role of that information in their force decision-making (Central-2, East-2, TOD-2). That officers documented the subject's mental health condition and how, when the subject had mental health issues that were known prior to the use of force, that information influenced their decision making improved significantly over last quarter (22% failure in Q3 2016 compared to 51% failure in Q2 2016).[33]

Sergeant's Evaluation of Mental Health Information

In 33 cases, sergeants indicated that a subject was in a mental health crisis. This is consistent with our findings from Q2 2016 where 35% of cases audited were identified as containing a mental health influence.

When sergeants indicated that a subject had mental health issues they indicated that the subject's mental health issues were known to the involved officer prior to the use of force in 16 cases.

When sergeants indicated that a subject had mental health issues they did not indicate how the subject's mental health issues influenced the officer's decision-making in 5 cases (Central/A-2, North/C-2, North/E-1). In 2 of these cases the investigating sergeants were actually officers who had been designated as acting sergeants. Neither of these officers received an EIS entry for this reporting error.

[31] DOJ Agreement: 77c
[32] DOJ Agreement: 74c ix
[33] DOJ Agreement: 74a i

In 2 of the cases, EIS entries were made for the investigating sergeant and this issue was addressed. In the last case, an EIS entry was made for the sergeant but it did not address this particular reporting error.

In 51 cases, sergeants did not indicate that the subject was in a mental health crisis. In 36 of these 51 cases, the sergeant did indicate, specifically, that the subject was not in a mental health crisis. In 15 cases, the sergeant failed to provide this information. We find that officer and supervisors both struggle with documentation of the absence of event details (i.e. force options not used, lack of subject injuries, and that the subject was not in a mental health crisis).

Subject Injuries & Treatment Received

Subject Injury Documentation

In 49 force cases, the sergeant investigating the force event selected that a medical response was necessary for the subject's injuries. In 43 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 (13), mental health issues (14), and pre-existing injuries (7). Of note: 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 audit found that supervisors were accurate in their documentation of the necessity for medical attention and the type of treatment the subjects received.

Reasons Medical was Requested

Reason Provided*	# of Cases
Injuries Sustained by the Subject as a Result of Force Event	43
Self-inflicted Injuries	10
Drug/alcohol Issues	13
Mental Health Issues	14
Pre-existing Injuries/Medical Issues	7

**In some cases medical was summoned for more than 1 reason.*

In 96% of cases audited, the sergeant made an attempt to obtain a statement from the subject detailing the event and any injuries.[34] This is similar to our findings from the Q2 2016 report where sergeants failed to obtain a statement from the subject (without explanation as to why) about 5% of the time. In three cases (East-2, North-1) the sergeant did not attempt to obtain a statement from the subject, or it was unclear as to whether or not the sergeant made an attempt to obtain a statement from the subject. In the case from North Precinct, an EIS entry was made for the sergeant who failed to document that the subject was transported to JDC (Juvenile Detention Center) before the sergeant could interview them. In one of the cases from East, the investigating sergeant has since retired and the EIS entry was not made. In the other case from East, analysts issued an Audit Findings Report, but failed to include this item on it. An EIS entry was made for this sergeant regarding the items that were on the Audit Findings Report.

[34] DOJ Agreement: 75c

Officer Documentation of Subject Injury & Treatment Received[35]

Subject Injury	Reports		Treatment Received	Reports
None	38		No Treatment Needed	47
Bruises	10		EMS at Scene	73
Abrasions	79		EMS at Precinct	6
Lacerations	48		Hospital – Admitted	10
Broken Bones	2		Hospital – Released	29
Pain	37		Treatment Refused	19
Other	28		Self-Treatment	1

The above table shows how often each category of injury was documented by officers within their reports. The total number of injuries is much higher than the previous two quarters because there was a change in the methodology of documenting suspect injury. In previous quarters the audit simply documented whether or not a suspect had an injury in the category. The current methodology captured each injury based on location of the injury. For example if a suspect had an abrasion to their hand and their knee, the new methodology would capture this as two abrasions, the old methodology would capture this as only one abrasion. Due to the addition of a category of injury for "pain", there was a drastic decrease in the "none" or no injury category. Previously the subjects who felt pain or soreness would likely be categorized as having no injury because of the lack of visible injury.

Officers documented injuries on a consistent basis. Ninety-one percent of the time officers documented subject injury or lack of injury within their reports. Nine of the 14 times officers failed to do so, the subject had no injury and the officer failed to document the lack of injury. The number of officers who did not document the lack of injury within their reports has decreased when compared to the 2 previous quarters. We estimate this number will continue to decrease with improved report writing directives. [36]

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. In prior quarters we identified that officers sometimes perceive injuries differently. However, in this quarter there were only two instances where officers differed on their documentation of a subject's injuries. We are encouraged to find no large gaps in the reporting of subject injury and treatment received and that the treatment received seems to be proportional to the types of injuries that are sustained.

Medical aid is requested when subjects sustain an injury from a use of force incident, when subjects are injured prior to police involvement (self-injury, mental health crisis, or unrelated injury) or is sometimes staged when there is a high likelihood that force will be used which may result in injury. For example, SERT callouts often stage medical when they believe the incident will result in a use of force in order to have no delay in procurement of medical assistance. In no cases that were audited this quarter did any supervisor identify that officers delayed calling for medical assistance.

The methodology for this quarter's audit was changed in order to address timeliness of medical procurement for suspects who had injuries. In order to assess whether or not medical aid was procured in a reasonable amount of time we captured what time medical response was requested using CAD (Computer Assisted Dispatch) call data obtained from BOEC (Bureau of Emergency Communication) and compared this time to the average time officers documented the force incident took place. This time approximation in minutes, plus documenting if supervisors identified that medical procurement was not

[35] DOJ Agreement: 74c v
[36] DOJ Agreement: 74c v

done in a timely manner allowed us to determine if subject's received medical care in a timely manner.[37]

The audit of timeliness of medical procurement identified no cases where officers did not request medical assistance within a timely manner. During the audit we identified 19 cases where the time difference between the average time officers noted that force was used and the time noted in the CAD call data that emergency services were requested was more than 5 minutes:

- In 5 cases medical was staged and arrived prior to force being used.
- In 3 cases medical was called to tend to an injured officer, not an injured suspect.
- In 4 cases the suspect was not injured from a use of force but medical was summoned for other reasons (in all 4 cases officers immediately called for medical as soon as the suspect complained of pain or showed indication that medical assistance was necessary).
- In the remaining 7 cases narrative reports all clearly stated that medical was called immediately after the force event concluded.

In 6 cases, one of the necessary timestamps was not available. In 2 of these incidents the officer did not enter the time force was used. In one case this was because the officer did not write an FDCR until the officer was told to after the AAR had been through part of the command review. In the second case the officer simply did not note the time. In the 4 other cases we were unable to obtain the time emergency medical services were called because the time was not noted in the CAD information. This sometimes happens when BOEC dispatchers are busy. In these 4 cases there were no indications within the command review or the subject's statement to believe that medical services were not procured within a timely manner.

There were 2 cases identified that included a suspect with a broken bone that occurred as a result of a use of force. In 1 case, an officer broke the humerus (forearm) bone while handcuffing a subject. When the officer heard the pop of the bone, the officer immediately called for medical assistance and removed the handcuffs in order to avoid aggravating the injury. In the review of the incident the command staff consulted an orthopedic surgeon. The surgeon stated that the injury was not surprising, that the bone is quite easy to break if twisting occurs and that this subject was at high risk for poor bone density. In the second case medical was requested within 5 minutes of the force incident. In this case a subject was taken to the ground after mule kicking an officer. This subject sustained a broken foot. It is unknown if the broken foot occurred during the takedown or during the kick to the officer as the subject was barefoot. [38] [39]

Specialty Units

In 100% of cases audited, officers called in specialty units in accordance with procedure. There were no cases audited in which the supervisor indicated that officers did not call in specialty units in accordance with procedure. This is an improvement compared to last quarter in which a supervisor indicated that an officer did not call in specialty units in accordance with procedure in 3 cases audited. The most common specialty unit requested was K9-5 cases followed by Project Respond-3, BHU-Behavioral Health Unit-2, Less Lethal-2, CNT-Crisis Negotiation Team-1, and SERT-1 case.

[37] DOJ Agreement: 74c v
[38] DOJ Agreement 74a v
[39] DOJ Agreement: 74c v

The audit identified 33 cases with a mental health component, in 36% of these cases at least one of the officers involved in the force event was also an ECIT officer. In 6 cases an ECIT unit was called to the scene. BHU was requested in 2 cases and Project Respond was requested in 3 cases.

Relative to the activation of specialty units, the most common conditions present and cited in officer narratives were: mental health component and the subject is armed with a weapon (8 cases), mental health component and custody is necessary (6 cases), mental health component and the subject is violent (5 cases), a subject has barricaded (2 cases), tactical apprehension of a subject is needed (1 case), mental health component and the responding officer requested ECIT (1 case), mental health component and the call is at a residential mental health facility (1 case), mental health component and the subject is threatening to jump from a bridge or structure into vehicular traffic (1 case).[40] [41]

Notification Requirements

A shift supervisor and PSD (Professional Standards Division) must be notified of every serious use of force case. In addition, PPB policy requires PSD and shift supervisor notification for use of force against a person with actual, or perceived mental illness. (Please refer to PPB directive 940.00 for the definition of serious use of force.)

A sergeant documented the required notification of PSD in their AAR in 95% of cases audited. Reasons articulated by the sergeant in their AAR for notifying PSD included: use of force against a person with actual or perceived mental illness (26 cases), serious use of force (10 cases), other reason (3 cases), and criminal conduct or allegation of criminal conduct (1 case). There were 2 cases where PSD should have been notified but no indication was found in the AAR that the notification was made (East/A-1, East/E-1).

In 88% of cases audited sergeants documented their notification of the shift supervisor. Reasons articulated by the sergeant in the AAR for notifying the shift sergeant included: use of force against a person with actual or perceived mental illness (23 cases), serious use of force (10 cases), other reason (4 cases), and criminal conduct, or allegation of criminal conduct (1 case). In cases where the sergeant indicated that they notified PSD, but there was no indication that a shift supervisor was notified, sergeants at Central Precinct (A-2, C-1) were the least likely to not include that information in their AARs. An East Precinct (A-1) sergeant also did not include whether a shift supervisor was notified, but did indicate that PSD was notified. 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; 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.[42]

In 4 cases a sergeant indicated in their AAR that the Detective Division was notified. The reason given for notifying the Detective Division was misconduct/criminal conduct in 1 case. Reasons given in the other 3 cases did not involve the conduct of the officer(s); reasons included bias crimes against a victim and the seriousness of a felony assault.[43]

[40] DOJ Agreement: 74a i
[41] DOJ Agreement: 74a iv
[42] DOJ Agreement: 75k
[43] DOJ Agreement: 75l

The audit found 1 case 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.[44]

The audit found 4 cases in which the investigating supervisor, shift commander or division commander found evidence of apparent misconduct by a PPB officer and reported the matter to PSD for review and investigation.[45]

See *Determination of Whether the Force was In/Out of Policy* section for further information.

EIS and Tactical/Training Issues Identified

Supervisors Request Additional Investigation when Necessary

Ninety-six percent of the cases audited this quarter either required no additional investigation, or a member of command identified that additional investigation was necessary. Analysts identified 3 cases that required additional investigation, which were not identified by any member in the chain of command (East-1, Transit-2). The Transit cases contained AARs that were incomplete. The case from East Precinct required additional investigation because the analysts identified that an AAR had not been completed for the case and created an Audit Findings Report indicating such.[46] [47]

Corrective Action Documented in EIS

An EIS entry is required for any officer who applies force (with the exception of PFA only). EIS entries from sergeant's are required to contain the following information; (1) case number, (2) nature of the incident, (3) whether the incident was in or out of policy, (4) any positive performance - as noted in the Sergeant's critique, and (5) any training deficiencies, policy deficiencies, or poor tactical decision -- including reporting errors.

- 95% of officer EIS entries included the case number
- 93% of officer EIS entries included the nature of the incident
- 91% of officer EIS entries included an indication of whether or not the event was within policy.
- 54% of officer EIS entries included any training deficiencies, policy deficiencies, or poor tactical decision -- including reporting errors.[48] [49]

Sergeant Did Not Document Training Deficiencies, Policy Deficiencies, or Poor Tactical Decisions In EIS

Precinct	A	B	C	D	E	Specialty	Total
Central Precinct	2	0	0	0	0	0	2
East Precinct	4	2	3	1	3	0	13
North Precinct	2	0	1	0	5	0	8
SERT	0	0	0	0	0	1	1
Traffic	0	0	2	0	0	0	2
Total	7	2	6	1	8	1	26

[44] DOJ Agreement: 77f
[45] DOJ Agreement: 77g
[46] DOJ Agreement: 77d
[47] DOJ Agreement: 77b
[48] DOJ Agreement: 75j
[49] DOJ Agreement: 77e

Reporting on DOJ SA item 75i has improved significantly when compared to the Q1 and Q2 Force Audit results, however a need for additional training around the documentation of corrective action and officer reporting requirements for sergeants is still needed.

When an officer's narrative was missing required information (witnesses, subject injuries, force option discrepancies, mental health info, etc.) the issue was addressed in the CHO's review most often (57%). The missing information was least likely to be addressed in the sergeant's review (28%) and the RU Manager's review (20%). When an officer's narrative was missing required information, the lieutenant addressed the issue in 35% of their reviews. Sergeants at East Precinct (East/A-3, East/E-2) were the least likely to address officer reporting issues in their reviews. East Precinct was followed by North Precinct sergeants (North/A-1, North/C-2, North/E-1), Central Precinct sergeants (Central/A-1, Central/C-1), and Transit sergeants (Transit/B-1, Transit/C-1) who failed to address officer reporting issues in their reviews.

The CHO was most likely to document the implementation of corrective action taken for any missing required information in an officer's narrative, or a missing FDCR (68% of CHO reviews requiring the documentation of corrective action taken). The RU Manager was the least likely (21%) to document in their review corrective action taken when there were material omissions or inaccuracies in an officer's use of force report, or for failing to report a use of force. The sergeant indicated in their review the required corrective action taken for any missing required information in an officer's narrative, or a missing FDCR in 23% of cases requiring this information. The lieutenant documented corrective action taken for any missing required information in an officer's narrative, or a missing FDCR in 32% of cases requiring this information. Sergeants at East Precinct were the least likely to document corrective action taken when there were material omissions or inaccuracies in an officer's use of force report, or for failing to report a use of force (East/A-3, East/B-1, East/C-6, East/E-4). North Precinct sergeants did not document corrective action taken when there were material omissions or inaccuracies in an officer's use of force report, or an officer failed to report a use of force in 11 cases requiring this information (North/A-4, North/B-1, North/C-3, North/E-3). In 5 cases requiring the information, Central Precinct sergeants did not document corrective action taken for any missing required information in an officer's narrative, or a missing FDCR (Central/A-3, Central/C-2). Sergeants at the Traffic Division during C shift did not document corrective action taken when there were material omissions or inaccuracies in an officer's use of force report, or an officer failed to report a use of force in 2 cases requiring this information. Transit Division sergeants did not document corrective action taken when there were material omissions or inaccuracies in an officer's use of force report, or an officer failed to report a use of force in 1 case requiring this information.[50]

Additional Training and Counseling

In 17 cases, sergeants did identify an additional training or counseling need. The most common training/counseling needs were related to (1) use of the X2 ECW, (2) waiting for the arrival of a cover officer, (3) handcuffing of subjects. This is consistent with the findings of previous quarters.

In 14 cases lieutenant's identified additional training or counseling needs. In 12 the cases these needs had already been identified by the sergeant, but in 2 cases the lieutenant identified a new training need, in both cases these were related to ECW use.

[50] DOJ Agreement: 75i

The RU Manager identified 7 cases where additional training or counseling was necessary. In 5 of these cases, a lower level of command had already identified a training issue. In the 2 unique cases where the RU Manager identified a training issue, the issues were related to (1) tactical use of a takedown and (2) delivery of an ECW warning.

The CHO identified 15 cases where additional training or counseling was necessary. In 10 of those cases, a lower level of command had already identified a training issue. In the 5 unique cases where the CHO identified a training issue, the issues were related to officer reporting.[51]

Command reviews identified 3 unique cases in which force may have been avoided (East/A-1, East/C-1, North/A-1). Unlike Q1 and Q2 2016, the most common tactic, or training issue identified that could have potentially avoided the use of force was not waiting for a cover officer. There was not one common tactic, or issue identified in Q3 2016.

> (1) Command found that the officer might have avoided using a takedown on a subject, if the officer had used a two-person escort hold from the beginning. Their supervisor counseled the officer, but the discussion was not noted in the officer's EIS discussion tracker. The officer is no longer with PPB.
> (2) The takedown used on a subject was determined to be avoidable by command if the officers had used de-escalation techniques. Their supervisor counseled both officers; the case was referred to IAD, and EIS entries were made for both officers. No further corrective action has been taken pending the outcome of the investigation.
> (3) Command found that an officer might have avoided using a takedown on a subject, if the officer had requested additional cover prior to escorting the subject to the patrol vehicle. The officer's supervisor counseled the officer and made an entry in the officer's EIS documenting the discussion.[52]

[51] DOJ Agreement: 75h
[52] DOJ Agreement: 75g