

LOS ANGELES POLICE COMMISSION

***REVIEW OF DEPARTMENT'S
QUARTERLY DISCIPLINE REPORT***

1st QUARTER, 2007



Conducted by the

OFFICE OF THE INSPECTOR GENERAL

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Inspector General

July 26, 2007

I. Introduction

The Consent Decree requires that the Department prepare a quarterly report regarding discipline imposed, including Categorical Uses of Force (CUOFs) found to be out of policy, within 45 days after the end of each quarter. The Department has completed its report for the First Quarter of 2007. The Police Commission (Commission) received its hard copy of the Department's Quarterly Discipline Report (Report) on May 21, 2007. On June 21, 2007, the Department provided the OIG with a revised Table L (Revised Table L), regarding CUOF incidents deemed out of policy by the Commission, to remedy inaccuracies in the originally submitted Table L which had been identified by the OIG. A copy of the Revised Table L is attached hereto for the Commission's reference. As required under Paragraph 89, the OIG has reviewed the Department's Report and submits its own Report to the Commission.

During this Quarter, the OIG again interpreted some of the statistical data contained in the various tables within the Department's Report. Section II below contains the OIG's analysis of some of the information found within the tables contained in the Department's Report and expands upon the information contained therein.

In Section III, the OIG discusses our review of cases closed during the First Quarter that contained at least one allegation of ethnic remark or gender bias. The OIG previously reviewed ethnic remark cases in our Discipline Report for the First Quarter of 2006 to ascertain whether these cases were being properly classified. Our 2006 review revealed that, in some cases, the Department was misclassifying what we believed should have been ethnic remark cases as improper remarks. The OIG also found that some gender bias cases were similarly being misclassified as improper remark cases. Our 2006 review further raised the larger issues of: whether cases which alleged activity by employees which could expose the City to potential liability for discrimination and hostile work environment were being properly investigated and adjudicated; whether appropriate discipline was being imposed; whether necessary training was being provided to employees involved in such activity; and whether, in the case of supervisors engaged in such behavior, issues of downgrade and/or demotion were being properly considered. The OIG decided to revisit these topics to evaluate the Department's progress in responding to our previous recommendations.

The OIG has noticed significant progress by the Department in classifying these types of cases since our 2006 Report was issued. The OIG, therefore, did not focus our current review on determining whether such cases were being properly classified, but instead focused on evaluating the handling of investigations which were properly classified. Overall, the OIG noticed a marked improvement in the quality of these investigations, though the OIG did note some investigative concerns in the four cases identified below. We also noted that most of the investigations we reviewed were fairly short in length, and employed what could be considered a short form template, including short paraphrases of essential interviews. Given the potential severity of the allegations made in these types of cases, we recommend that the Department encourage the full exploration of all of the issues raised by these types of complaints. Ultimately, we believe that this is a relatively minor concern in light of the progress made by the Department since our last Report on these topics.

In Section IV, the OIG discusses cases closed during the First Quarter of 2007 that were determined to be Out of Statute (OOS). The Report included seven such cases which were closed during the First Quarter. The OIG was provided with additional documentation to explain why these cases fell OOS and what remedial action, if any, was taken to avoid similar recurrences. Finally, Section V contains our review of the eleven CUOFs deemed Out of Policy by the Commission, which were closed during the First Quarter, and which are enumerated on the Revised Table L.

II. Analysis of Statistical Information Within the Department's Report

As a result of our review of the Department's Report, we found additional information to aid the Commission in its review and evaluation of the discipline imposed during this Quarter. On May 24, 2007, OIG staff met with TEAMS II staff (Meeting) to discuss certain items in the Report, including modifying Table C (see discussion below).

Executive Summary

Using the information contained in the Executive Summary, we determined that the percentage of Sustained allegations was 14.9% (total of Sustained allegations/total allegations = 763/5122 = 14.9%). Also using the information in the Executive Summary, we determined that the percentage of Sustained allegations for each of the "Top Allegation" classifications was as follows, in descending order of sustained rate:

Allegation	Sustained Rate	No. of Sustained Allegations/ Total Number of Allegations
Preventable Traffic Collision	96.3%	182/189
Failure to Qualify	91.4%	64/70
Neglect of Duty	16.3%	177/1085
False Statements	15.5%	16/103
Unbecoming Conduct	11.2%	118/1058
Unauthorized Tactics	10.6%	18/170
Unlawful Search	7%	8/114
Discourtesy	2.8%	24/868
False Imprisonment	<1%	3/309
Unauthorized Force	<1%	5/517

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Tables C and E – Allegation Summary / Bureau-Allegation Summary (Sustained Only)

Classification	Sustained Allegations/ Total Allegations	Sustained Rate	Percentage of Total Allegations	Number of Accused Employees	Number of Employees w/ Sustained Allegations ¹
Insubordination	16/16	100%	0.3%	10	10
PTC	182/189	96.3%	3.7%	188	182
FTQ	64/70	91.4%	1.4%	69	63
FTA	35/41	85.4%	0.8%	40	34
Alcohol Related	18/22	81.8%	0.4%	19	15
Shooting Violation ²	9/11	82%	0.2%	8	8
Off-Duty Altercation	6/8	75%	0.2%	5	3
Accidental Discharge	2/3	66.7%	0.06%	3	2
Improper Remark	26/58	44.8%	1.1%	36	16
Dishonesty	5/13	38.5%	0.3%	7	1
Narcotics	9/27	33.3%	0.5%	10	4
Misleading Statements	2/9	22.2%	0.2%	8	2
Failure to Report Miscon.	2/9	22.2%	0.2%	8	2
Domestic Violence	10/47	21.3%	0.9%	19	5
Neglect of Duty	177/1085	16.3%	21.2%	693	130
False Statements	16/103	15.5%	2%	73	10
Unbecoming Conduct	118/1058	11.2%	20.7%	590	61
Theft	4/36	11.1%	0.7%	20	2
Unauthorized Tactics	18/170	10.6%	3.3%	134	18
Unlawful Search	8/114	7%	2.2%	79	8
Ethnic Remark	2/41	4.9%	0.8%	33	2
Sexual Misconduct	1/34	2.9%	0.7%	11	1
Discourtesy	24/868	2.8%	16.9%	534	16
Discrimination ³	1/40	2.5%	0.8%	34	0
False Imprisonment	3/309	1%	6%	234	3
Unauthorized Force	5/517	1%	10.1%	287	5
Racial Profiling	0/80	0%	1.6%	72	0
Other Policy/Rule	0/66	0%	1.3%	28	0
Retaliation	0/45	0%	0.9%	28	0
Excessive Force	0/12	0%	0.2%	11	0
Miscellaneous Memo	0/8	0%	0.2%	8	0
Gender Bias	0/7	0%	0.1%	7	0
Service	0/5	0%	0.1%	1	0
Use of Force	0/1	0%	0.02%	0	0

A few points of clarification should help explain some of the entries in the above table. For example, the Department used the classification “Excessive Force” prior to 1993. It was replaced by “Unauthorized Force.” Discussion with staff from TEAMS II during the Meeting revealed that, in these 12 older cases, the investigations were inadvertently re-opened. As a

¹ Data in this column was taken from Table I1 in the Report. Employees are separately counted for each complaint and for each allegation type; thus a single employee may be counted repeatedly. Accordingly, the numbers in this column do not match the exact number of employees against whom the allegations were sustained.

² This includes one Sustained allegation which was inadvertently listed in the Department’s Report as “Undetermined.”

³ The one Sustained Discrimination allegation was against an “Unknown” employee.

result, they were assigned a new final close date and were included in the First Quarter 2007 Report. The relevant TEAMS II screen has since been changed so that the default command is to re-open cases administratively, thereby keeping the cases' original close date and preventing this error in the future. Similarly, the eight "Miscellaneous Memo" allegations included in the table actually date back to 1966 and 1968 but were included in the Department's First Quarter 2007 Report due to the same inadvertent re-opening of the underlying cases. "Use of Force" is one of six initial allegation classifications recently implemented by IAG. Complaints initially categorized as "Use of Force" refer to those related to CUOF incidents administratively disapproved by the Commission. They are subsequently re-classified, either as Unauthorized Force, Unauthorized Tactics, or Shooting Violation after the complaint is adjudicated. Thus, a case will never be closed under a "Use of Force" allegation, and the sustained rate for such allegations will always be zero. During the Meeting, IAG and TEAMS II staff agreed that initial classification categories, such as "Use of Force," would not appear in Table C in future Reports.

Table F – Allegation Summary by Employee Rank – Listed by Allegation Type

Using the information in Table F (and elsewhere), the OIG obtained Sustained allegation rates, broken-out by rank, calculated both by total allegations, and by total allegations excluding Preventable Traffic Collisions (PTCs), Failures to Appear (FTAs), and Failures to Qualify (FTQs). Our results are depicted in the below table.

	Sustained Allegations/ Allegations	Overall Sustained Rate	Sustained Allegations/ Total Allegations (Minus PTCs, FTAs, & FTQs)	Overall Sustained Rate (Minus PTCs, FTAs, & FTQs)
Allegation Total	763/5122	14.9%	482/4822	10%
Staff Officer	0/26	0%	0/26	0%
Captain	0/38	0%	0/38	0%
Lieutenant	9/64	14.1%	4/57	7%
Sergeant	38/284	13.4%	21/264	8%
Detective	86/336	25.6%	52/301	17.3%
Police Officer III	152/834	18.2%	95/773	12.3%
Police Officer II	340/2152	15.8%	191/1996	9.6%
Police Officer I	19/222	8.6%	5/208	2.4%
Reserve Officer	10/49	20.4%	9/48	18.8%
Detention Officer	6/43	14%	6/43	14%
Civilian Management	1/4	25%	1/4	25%
Civilian Personnel	88/173	50.9%	85/169	50.3%
Unknown/Invalid	14/879	1.6%	13/895	1.5%

Whereas 14.9% of all misconduct allegations were Sustained during this quarter, 10% of all allegations were Sustained when PTCs, FTQs, and FTAs were removed.

III. Review of Cases

A. Methodology

This quarter the OIG looked at whether cases which involved ethnic remark or gender bias allegations were being properly investigated, and whether those with Sustained allegations were receiving appropriate penalties and training. Pursuant to Consent Decree paragraph 93, complaints involving ethnic remarks are to be investigated by Internal Affairs Group (IAG). If Sustained, the Department's "Management Guide to Discipline" (July 2004) for sworn employees (Sworn Guidelines) recommends a five to nine-day suspension for a first-time Sustained complaint of ethnic remark. For Civilian employees, the Civilian Guide to Discipline Standards (August 2005) (Civilian Guidelines) recommends a five-day suspension to discharge. For a first-time Sustained complaint of gender bias, the Sworn Guidelines recommend a written penalty to nine-day suspension for sworn employees, and the Civilian Guidelines recommend an oral warning to 20-day suspension for civilian employees.

An ethnic remark is defined by the Department as "an improper remark(s) showing ethnic/culture bias." (Sworn Guidelines, at p. 67). Among the definitions of gender bias is an "improper remark(s) showing sexual/gender bias." (*Id.*) The companion classification to gender bias is sexual harassment, which is defined to include to "create/allow hostile work environment showing sexual/gender bias" (*id.*) as well as "quid pro quo"⁴ sexual harassment.

For this Report, the OIG limited the cases reviewed to those which were initiated after the date of our First Quarter 2006 Report, or July 16, 2006. During the First Quarter of 2007, thirteen such complaints were closed with at least one allegation of ethnic remark or gender bias. Eleven of the cases were reviewed. The other two cases were generated as the result of an Ethics Enforcement Section sting to evaluate whether a complaint would be taken. Since there was no subsequent investigation in these cases, they were, therefore, de-selected.

In reviewing the 11 cases, a matrix was utilized by the first and second level reviewers. This matrix contained 35 questions designed to evaluate the quality, completeness, and findings of the completed investigation, including whether the discipline imposed was justified and appropriate in light of the surrounding circumstances, the employee's disciplinary history, and the standards enunciated in the Department's Sworn Guidelines and the Civilian Guidelines. In addition, a Crib Sheet was used to assist in answering the questions on the matrix.

OIG staff also reviewed tape-recorded interviews in two cases. In reviewing the taped interviews, OIG staff utilized a matrix containing 17 questions designed to evaluate whether: (1) the interviews were properly paraphrased to include all relevant testimony; (2) all allegations raised by the complainant were properly formed; (3) any additional allegations raised during the interviews were addressed in the completed investigation; (4) the interviews themselves were conducted properly (e.g., whether the interviewer used inappropriate or leading questions, or adopted a hostile or inappropriate tone with the witness); and (5) logical follow-up questions were asked by the interviewer. No secondary level review was conducted for the tape reviews.

⁴ Quid pro quo sexual harassment is when a person's submission to or rejection of sexual advances or conduct of a sexual nature is used as the basis for employment decisions affecting the individual, or the individual's submission to such conduct is made a term or condition of employment.

B. Analysis of Ethnic Remark and Gender Bias Complaints

Of the 11 cases reviewed, the OIG identified investigative issues in the following four cases.⁵

CF No. 06-3905

This complaint was filed by a civilian employee (A1) against a supervisory civilian employee (A2). According to A1, A2 admired a picture of A1's son that was on A1's desk, and inquired about the ethnicity of A1's spouse. A1 responded that A1's significant other was biracial (Black and White), and according to A1, A2 stated "I'm sorry for your son. He's Black, White, and Mexican." A1 was offended. A1 informed A2 that he/she was from Nicaragua, not Mexico. Another employee (W1) indicated that she only heard a portion of the conversation during which she heard A1 tell A2 that A1 was Nicaraguan.

A2 denied ever stating, "I'm sorry for your son. He's Black, White, and Mexican." According to A2, he/she asked A1 whether A1 was Mexican, and A1 responded that he/she was Nicaraguan. A2 stated in his/her interview that he/she did not know that Hispanic people made such distinctions as between Mexican and Nicaraguan, and stated that he/she did not intend or believe that the question, "Are you Mexican?" was derogatory in any manner towards A1.

The complaint resulted in one allegation of ethnic remark, which was adjudicated as Not Resolved. The adjudicator suggested that A2 attend additional diversity/sensitivity classes, but did not require that A2 attend such classes.

Our review of the interview tapes of the complainant revealed that A1's interview had not been properly paraphrased by the investigating officer (I/O). The paraphrase states that A1 took offense to the statement regarding A1's son's ethnic background "because [A1] is Nicaraguan by birth," implying that A1 was offended merely because A2 mistook A1's actual nationality. However, our review of the tape revealed that in response to being asked what offended A1, A1 responded that A2 was "attacking [A1's] son's race." Indeed, A1's belief that his/her son's race was being attacked was the reason A1 gave for not being willing to participate in the Alternate Complaint Resolution process regarding this incident.

Our review further revealed that A1 indicated in his/her interview that A2 had made previous comments regarding the race of A1's significant other that A1 had "just let go." This information was not included in the paraphrase of A1's statement, and a review of A2's interview tape revealed that the I/O did not question A2 regarding these alleged past statements.

The adjudicator described the relationship between A1 and A2, and A2's complaint history as follows: "The investigation did not indicate any previous conflicts between A1 and A2, nor is there anything in A2's complaint history to indicate a pattern of improper remarks." However, we believe the information missing from the paraphrased statement could have influenced the adjudicator's ultimate determination. The I/O should have followed up on A1's statements that A2 had previously commented on the ethnicity of A1's significant other in the past to ascertain whether A2 had a pattern of making inappropriate ethnic remarks. Further, including these

⁵ On July 25, 2007, OIG staff met with staff from IAG regarding concerns the OIG had identified in several cases. The four cases described below represent those cases which the OIG and IAG agreed merited further discussion.

statements in the paraphrase of A1's statement may have caused the adjudicator to rethink his/her claim that there was nothing to indicate a "pattern of improper remarks" by A2.

The adjudicator determined that because A1 and A2 each gave differing accounts of the incident, and because A2 claimed that the question regarding A2's ethnicity was not meant to be derogatory, as well as the lack of past conflicts between A1 and A2 and improper remarks on the part of A2, plus the lack of independent witnesses, a Not Resolved finding was warranted. The OIG believes that, at a minimum, A2's admission of making some reference to A1's ethnicity, coupled with A1's description of previous similar incidents, warranted directed training on the part of A2 given A2's apparent lack of understanding regarding the propriety of making such comments in the workplace, as well as A2's statements to the I/O that demonstrated a lack of understanding of different Hispanic nationalities, and the fact that A2 was a supervisory level employee. While the OIG was pleased that the Department properly classified this as an ethnic remark case, the OIG believes that the quality of the investigation was hampered by poor paraphrasing of interview statements and a failure to ask logical follow-up questions.

In CF. No. 06-4512, the complainant sent in a Complaint of Employee Misconduct Form (Form) alleging that an unknown officer pulled him/her over, stated that the complainant was speeding, called the complainant an "idiot," and used profanity. The complainant indicated that during the stop, the accused officer went to his/her vehicle for approximately 20 minutes, and the complainant called his/her brother-in-law to come to the scene. The complainant alleged that the officer told the brother-in-law that if he did not leave, the officer was going to tow both the complainant's and the brother-in-law's cars, and said to the complainant, "I bet you f**king Mexicans don't have a license." The complainant wrote that he produced the license for the officer, and after the officer wrote down the corresponding information, the officer informed the complainant that it was the complainant's "lucky day" and that no citation was going to be issued, but that if the officer saw the complainant again he would pull the complainant over and ticket the complainant for "anything I can." The complainant wrote that he asked the officer for the officer's badge number, but the officer just turned around and said, "Have a nice day."

No accused officer was located, and the complaint was adjudicated as Insufficient Evidence to Adjudicate. We commend the I/O for performing what appears to be an exhaustive search of officer logs to attempt to locate the incident, as well as requesting a computer search of radio communications for the time and date in question. However, in the "Consent Decree Issues" section of the investigation, the I/O included the following: "Complainant opted to provide a written complaint, and declined to provide a tape-recorded interview due to time constraints." There is nothing on the complaint form prepared by the Department, nor the Form filled out by the complainant, indicating such information. We also reviewed the I/O's chronological notes, and found no indication of the complainant declining to be interviewed. Further, the complainant included his address and phone number on the form he submitted.

We believe that more information should have been included in the investigation to support the claim that the complainant declined to be formally interviewed. The OIG further noted that no information was provided as to whether the complainant's brother-in-law would consent to an interview. We forwarded our concerns to IAG on June 29, 2007. On July 3, 2007, IAG indicated they agreed with our concerns and would be conducting a supplemental investigation to address our concerns.

In CF No. 06-4213, the complainant alleged, among other things, that the accused officer told the complainant that the complainant and his/her significant other were in the country illegally and did not have any rights. Although this would constitute an ethnic remark allegation, the investigation was initially handled by the area, in contravention of Paragraph 93. The area at some point properly recognized this concern, and sent a memo to IAG requesting that they take over the investigation. Unfortunately, the request was not made until over two months after the complaint was initiated, and nearly two months after the interviews for the complaint had been conducted. IAG responded that its review of the case file indicated that the investigation had already been completed, and therefore no further investigation was required.

Further, though the complainant indicated that she spoke Spanish and was interviewed in Spanish, the complainant was sent a letter explaining the disposition of the complaint in English. We understand that the Department does not currently provide close out letters, informing the complainant of the results of the Department's investigation, in any language other than English. We would encourage the Department to consider providing reply letters in a language which could be understood by the complainant. We have discussed this issue with IAG, and they have indicated that they will undertake a project to explore the feasibility of doing this.

In CF No. 06-4033, a Department of Children and Family Services (DCFS) employee was at a police station on official business. While in the restroom, the DCFS employee overheard one Hispanic officer call another Hispanic officer "Aunt Jemima." The officer on the receiving end of the comment stated, "Don't call me that." The DCFS employee was offended, and tried to view the name tag or badge number of the officer who made the comment, but the officer exited the restroom and walked away before he/she could do so. The DCFS employee notified the watch commander, and a complaint was initiated. However, the accused officer was never identified. The I/O attempted to subsequently contact the DCFS employee by telephone several times, but never received a return phone call.

Given that there was no name or badge number to go by in ascertaining who the accused officer was, the OIG believes that it would have been more prudent for the watch commander to attempt to locate the accused officer at the time the complaint was made, while the DCFS employee was there and the accused employee may have still been at the station, instead of waiting over two months to first attempt to contact the complainant. Further, while we commend the I/O for diligently attempting to locate the complainant by telephone, we saw no indication that the I/O attempted to contact the complainant by letter as well.

IV. Discussion of Out of Statute Cases

During the First Quarter of 2007, seven cases were closed which were determined to be Out of Statute (OOS).⁶ These cases raised questions about whether appropriate remedial action was being taken to ensure cases are closed within statute. We reviewed seven Intradepartmental Correspondences (15.2s) related to these cases provided to us by the Department, as well as the full case files of the three cases that did not allege either a PTC or FTA. We determined that, in all seven cases, it was an administrative oversight on the part of Department employees, not the actual length of the investigation, which resulted in these cases exceeding the one-year statute.

⁶ These OOS cases are listed in Table N: Out of Statute Complaints, on page 17.

A review of 15.2s and related case files revealed that cases closed OOS during the First Quarter of 2007 exceeded the statute of limitations for two main reasons:

- The party or parties responsible for processing cases through the proper chain of review failed to do so in a timely manner, if at all. This was especially true for cases alleging a PTC, given the various levels of investigation required.⁷ Inaction or untimely action stalled the complaint investigation until it exceeded the statute of limitations. For example, CF No. 06-3954, a relatively straightforward PTC investigation, sat at the area level for five months without any action. In CF No. 05-6411, a supervisor failed to complete his/her review duty in a timely manner, despite being given several extensions.
- The case was tolled in a manner that did not adhere to the tolling guidelines outlined in Government Code § 3304 and City Charter §1070. As a result, the case was adjudicated as OOS once the inaccurate tolling was identified.⁸

While allowing cases to fall out of statute is a concern, the OIG is equally, if not more concerned, that in four out of seven cases, the Department did not appear take any remedial or corrective action.⁹ Remedial action(s) could include anything from issuing a comment card or a notice to correct, filing a 1.28 complaint form for Neglect of Duty against the responsible party, requiring training,¹⁰ or creating a system to track pending cases or workload. For example, the involved division in CF No. 06-4573 instituted monthly audits of pending investigations to ensure none would exceed the statute in the future.

We commend the Department for taking corrective action in three cases. However, the Department should ensure that administrative procedures for sending cases through various levels of review, particularly in more serious cases, are conducted in a timely manner.

V. CUOFS Adopted Out-of-Policy or Administrative Disapproval by the Commission

During this First Quarter, eleven CUOF incidents were closed in which the Commission adopted a finding of out-of-policy or Administrative Disapproval (AD). Three were Officer Involved Shooting (OIS) cases, four were Law Enforcement Related Injury (LERI) cases, three were Negligent Discharge (ND) cases, and one was an In Custody Death case. In all but one case, OIS No. 04-085, the Commission adopted the findings of the COP.

OIS No. 04-085

Officer A was investigating an armed residential robbery. Four possible subjects were subsequently identified, including Subject 1. Officer B and Officer C met with Officer D and provided him/her with information gathered on Subject 1 and the residential robbery. Officer D was also given information on a series of home invasion robberies that had occurred two months prior, where the subjects were armed with handguns and concealed their faces with ski masks.

⁷ In PTC cases, there are several levels of review, from the incident's respective Traffic Division to the Department Fleet Safety Coordinator, through the accused officer's division, and, ultimately the involved bureau.

⁸ The cases that were improperly tolled were CF Nos. 05-6238 and CF No. 03-0701.

⁹ No remedial or corrective action was taken in connection with CF Nos. 03-0701, 06-5180, 06-3670, or 06-3954.

¹⁰ Training was required for one employee and a 1.28 was initiated against a second employee for letting CF No. 05-6411 fall OOS. Training was proposed as a remedy for CF No. 05-6238.

Officer D then briefed Officer E and Officer F regarding the information he/she obtained. Officer D submitted a surveillance worksheet to Officer G who approved it.

The surveillance team included Officers E, and H through T. During the briefing, Officer D provided the team members with the surveillance worksheet that contained a photograph of Subject 1 and a description of his vehicle. Officer D also informed them that Subject 1 had been identified as a subject in a residential robbery where several weapons were taken and the victims were threatened with death, and that 14 home invasion robberies had occurred in the area.

The Officers began their surveillance at Subject 1's residence. The Officers then followed Subject 1 for several hours, noting that when he slowly drove down several residential streets, it appeared that he was "casing" the area in preparation for a burglary. The next day, the entire surveillance unit was scheduled for training, and they postponed further surveillance of Subject 1 until the following day. On the third day, Officers U and V joined the surveillance team, were briefed on the case and given the surveillance worksheet by Officers D and L. The surveillance team observed Subject 1 exit his home with his girlfriend, Subject 2. The pair then entered Subject 1's vehicle and drove to the block where they picked up Subject 3. Subject 1 then drove to the same residential area in which he had previously been observed "casing" homes. At one point, Subject 1 stopped his vehicle, and he and Subject 3 switched seating positions. Subject 3 then drove to a street where Subject 1 and Subject 2 exited the car and ran to the front yard of the location when Subject 3 drove away. Subject 2 knocked on the front door while Subject 1 ran along the west side toward the rear of the residence. After several minutes, Subjects 1 and 2 ran from the residence and met Subject 3 who had returned with the car. Subjects 1 and 2 entered the vehicle, while Subject 3 then drove away followed by the surveillance team.

Officers K and T approached the residence and noted that the rear window was forced open, an alarm had been activated, and the rear bedroom appeared to have been ransacked. After confirming that a burglary had occurred, Officer T advised the surveillance team of his/her observations.

Officer J advised the surveillance team to locate a safe location to initiate the Vehicle Containment Technique (VCT)¹¹ and to arrest the Subjects. When the Subjects and the surveillance team neared an intersection, Officer V initiated the VCT. As the surveillance team approached, Officer V, who had positioned his/her vehicle in front of the Subjects' vehicle, began to slow down. Officer N then positioned his/her car along the driver's side of the Subjects' vehicle while Officer L positioned his/her car behind it. When the signal at the intersection turned red, the officers effectively blocked the movement of the Subjects' car. After positioning his/her vehicle in front of the Subject's car, Officer V exited and ran to a nearby liquor store for cover. Officer L, M, N, and U exited their vehicles, took cover behind their respective vehicle doors, and drew their firearms. Officer L, M, and N then ordered the Subjects to stay in the vehicle and to raise their hands.

Subject 3 complied with the Officers' commands and remained in the car while Subjects 1 and 2 exited. Subject 1 looked toward Officers L and U and began to yell obscenities at them. Officer U, who was armed with a shotgun, focused his/her attention on Subject 1 who began to side step

¹¹ The VCT has inherent risks that are not seen in the traditional high-risk felony stop. The VCT is used as a tool to effect the containment and arrest of armed and dangerous criminals whose escape would pose a significant risk to the community.

toward the east sidewalk. Officer U ordered Subject 1 and 2 to put their hands up and to get down on the ground. Subject 1 did not comply and berated the officer as he continued to step eastbound toward the sidewalk. When he reached the sidewalk, Subject 1 walked northbound while looking back toward Officer U. According to Officer U, Subject 1 was non-compliant and repeatedly moved his hands up and down to emphasize his words. Officer U sought cover behind the left side of a parked car and continued to order Subject 1 to get his hands up. Officer U then noted that, unlike his previous movements, Subject 1 turned towards his left and dropped both of his hands towards his waistband as if attempting to arm himself, which Officer U described as a "steady . . . sturdy motion where you come straight down." Officer U also stated, "when [Subject 1] did that motion right there towards his waistband area . . . he scared me to death, I thought he was arming himself and I thought I was gonna be fired upon."

Officer U then fired one round at Subject 1 from a distance of approximately 23 feet, striking him in the left upper chest and abdomen area. Subject 1 then walked a few steps, sat down facing the detectives and said, "Why the f**k did you shoot me?" Officer U then moved toward the rear of the car he/she used as cover and assumed a barricaded position while maintaining visual contact on Subject 1. In doing so, Officer U stated that he/she "almost shot Subject 1 again 'cause he was down by his waistband again, but then his hands dropped all the way down to the back of his legs." Officer H and I then arrived at the scene, drew their service pistols, and took a position of cover. At that moment, Subject 2 ran to Subject 1 and sat on his lap, essentially blocking Officer U's view of Subject 1. After repeated orders to move away from Subject 1, Subject 2 ran to the front of the liquor store where she was taken into custody. Moments later, Subject 1 was taken into custody by Officer W without further incident. Subject 1 was eventually transported to a hospital where he underwent surgery for injuries to his lower chest, left upper quadrant, left gluteal and flank areas of his body.

The COP noted that the VCT was performed properly. However, when Officer U deployed away from his/her vehicle to track Subject 1, he/she deployed to a position that exposed himself/herself to Subject 1 that remained in the vehicle. The COP would have "preferred that when Officer U deployed away from his/her vehicle, that he/she had utilized an adjacent vehicle that was parked at the curb for cover." The COP also noted that Officer L and Officer I "did not communicate with [Officer U] and advise [him/her] that they were in a position to assist [him/her] while [he/she] was dealing with two subjects." The COP determined that Officer I, L, U, and V would benefit from additional tactical training and directed the CO to schedule training for these officers at Training Division (TD).

The Commission adopted the COP's recommendations regarding tactics but recommended that Officer V receive Divisional Training in the proper application of the VCT. Officer V initiated the VCT in a high traffic area approximately 65 feet from a preschool. The Commission would have preferred that he/she had taken additional steps to ensure that the area in which the VCT was initiated did not include a preschool, given that an errant bullet could have struck a child or that Subject 1 could have entered the school and created a barricaded/hostage situation.

Consequently, the COP found that the actions of Officers H, I, J, L, N, O, U, and V in drawing and exhibiting their firearms to be in policy, requiring no action. The Commission concurred with the COP's recommendation.

In the area of Use of Force, the COP noted that Officer U, who was armed with a shotgun, ordered Subject 1 to put his hands up and to get down on the ground. Instead, Subject 1 walked away from Officer U while "looking back and forth" at the Officer. The COP also noted that Subject 1 repeatedly dropped his hands and questioned why he was being stopped. Officer U then re-deployed to the front left of a parked vehicle and repeatedly ordered Subject 1 to get on the ground, but he did not comply. Officer U stated that Subject 1 had his hands raised shoulder level and that Subject 1's left side was facing away from him. Subject 1 then "dropped his hands to his waistband area in a smooth motion as if to arm himself." Fearing that Subject 1 was about to arm himself, Officer U fired one round at him striking him in the abdomen area. Subject 1 stopped his aggressive actions and was eventually taken into custody.

Consequently, the COP determined that Officer U reasonably believed Subject 1 presented an immediate threat of serious bodily injury or death. Subject 1 had been observed committing a residential burglary and was identified as having participated in an earlier residential burglary where he threatened the victims with death. Additionally, Officer U had knowledge that firearms were taken in that earlier burglary. The COP noted that it was reasonable for Officer U to assume, based on the circumstances known to him at the time, that Subject 1 was armed, and that Officer U's belief that Subject 1 was arming himself was reasonable under the circumstances.

Per Department policy, "[a]n officer is authorized to use deadly force when it reasonably appears necessary to protect himself/herself or others from an immediate threat of death or serious bodily injury." Given this policy, the Commission found that it was not reasonable for Officer U to believe he was confronted with an immediate threat of death or serious bodily injury.

According to the statements of Witnesses 3 and 4, and Subject 2, Subject 1 was shot after dropping his hands in a manner indicative of someone attempting to run away. Witness 3 noted that he "didn't see no [sic] weapon and that he [Subject 1] didn't seem like he wanted to reach in his pants, he was just walking away and he just decided to run." According to Witness 3, "he didn't see nothing" [referring to a gun] and also "stood there the whole time." Witness 3 also indicated that had he thought that Subject 1 was armed, he would not have remained there.

Although Department policy does not always require an officer to see a gun or a reasonable facsimile thereof before deadly force is authorized, he/she must be able to articulate justification beyond the subject's furtive movements and his/her failure to follow directions before deadly force is justified.

The Commission found that the use of deadly force by Officer U should be classified as out of policy requiring, Administrative Disapproval (AD).

A complaint investigation was initiated under CF No. 05-1337. This investigation alleged that Officer U, while on duty, discharged his/her shotgun, which resulted in an AD finding. The allegation was Sustained, and Officer U received an Official Reprimand as well as tactical firearms training at TD. We believe this was an appropriate penalty in light of the lack of any real discipline history for this long-tenured employee, the fact that this incident occurred as part of a quickly unfolding and possibly dangerous situation, the fact that Officer U believed Subject 1 to have been involved in an armed robbery, and the fact that there was disagreement within the Department as to whether Officer U's use of force should have been deemed out of policy.

OIS No. 05-061

Officers A, C and D were working with supervisory Officers B and E, and a federal task force aimed at firearms-related criminal activities. A federal arrest warrant had been issued for the arrest of Subject 1 on charges of narcotics and firearms sales. Officers A through C proceeded to a target apartment in an unmarked police van, attired in plain clothes. The target apartment building was a three-story building, with parking on the ground floor and apartments on the two floors above. The entrances to the apartments were located along three-foot-wide open-air walkways on each floor.

The Officers arrived at the apartment building at around dusk and parked their van on a side street. From their position, the officers could see the side of the building where the target apartment was located. Officer A broadcast that they were "Code 6."

A short time later, the Officers observed Subject 1 and Subject 2, Subject 1's brother, emerge from an apartment and loiter outside the front door. The Officers were unable to positively identify Subject 1. The Officers' attempt to use a camera with a zoom lens to get a clearer view of the individual was unsuccessful. The Officers were not equipped with binoculars.

The Officers had been in contact with a Special Agent with the Bureau of Alcohol, Tobacco and Firearms (ATF), who was also working with them and who partnered with Officer D. The Special Agent and Officer D responded to the apartment building to assist the other officers.

Officer B contacted Officer E, who was off-duty, via cellular telephone and advised Officer E of the officers' location, that they had located an individual who looked like Subject 1, and they had not yet positively identified him. Officer E instructed the officers to notify him/her if they succeeded in identifying and arresting Subject 1.

The Officers decided that Officers A and B would meet the Special Agent and Officer D in front of the apartment building while Officer C stayed in the van to maintain observation of the individuals outside the apartment. The Special Agent and Officer D then proceeded toward the apartment building and parked approximately one house away from it. The Officers and the Special Agent met in front of the apartment building to form a tactical plan to approach it. It was decided that the best course of action was to go to the third floor, proceed to the north end of the building and then come down the stairs at the north end of the building.

Officers A, B, D and the Special Agent did not carry police radios with them, but kept in contact with Officer C via cellular telephone. The officers and the Special Agent were not wearing ballistic vests or raid jackets.

Officers A, B, D, and the Special Agent proceeded to the third floor, walked to the north end of the building and came down the north stairs to the second floor. Officers A and B were to enter the walkway first and make contact with the first individual in the event they could positively identify him as Subject 1 while Officer D and the Special Agent were to cover the second individual (Subject 2) and keep him from interfering. Officer C advised Officer A that the subjects were on the walkway outside the front door of the subject apartment.

Officer B opened the door to the walkway, and they all walked out onto the walkway with Officer B first, Officer A second, the Special Agent third, and Officer D fourth. Once they began to walk toward the subject apartment, it became apparent that one of the individuals in front of the apartment was Subject 1. Subject 1 was standing north of Subject 2. Based on how narrow the walkway was, Officer B believed that his/her best course of action was to deviate from the original plan and to take control of Subject 2 to facilitate the arrest of Subject 1 by the other officers/agent. Officer B walked past Subject 1 and made contact with Subject 2 while Officer A approached Subject 1. The Officers identified themselves, and Officer A attempted to take Subject 1 into custody. Subject 1 initially acted as though he was going to comply with Officer A's commands. Officer A held Subject 1's right arm to begin handcuffing him. Subject 1 then began to resist and lunged into the apartment, taking Officer A with him. Subject 1 and Officer A fell to the floor inside the apartment where a physical struggle ensued.

Officer B observed Officer A grappling with Subject 1 inside the apartment. Officer B then diverted his attention from Subject 2 and moved toward Subject 1 in order to assist Officer A. Officers A and B struggled to obtain control of Subject 1 inside the apartment, telling him to "stop resisting" as they did so.

Officer D observed Subject 1 lunge into the apartment, and fearing he may be arming himself, Officer D drew Officer D's service pistol. Once Officer D realized that other officers were focused on Subject 1, and that Officer D would need to assist the Special Agent with Subject 2, Officer D holstered Officer D's service pistol. The Special Agent and Officer D then moved past the front door of the apartment to take control of Subject 2. Subject 2 resisted and attempted to move toward Subject 1.

Subject 1 was got up from the floor and back out the front door of the apartment, as Officer A continued holding onto Subject 1's right arm. As Subject 1 crossed the front door threshold, the Special Agent saw Subject 1 produce a handgun. The Special Agent told the Officers, "He's got a gun." Officer B released his grip on Subject 1 and drew Officer B's service pistol. Officer A asked which subject had the gun. The Special Agent advised that it was Subject 1. Officer A stepped back from Subject 1 and drew Officer A's service pistol. Officer A observed Subject 1 with a gun in his left hand. Officer A observed Subject 1 move his hand to the left in the direction of the other Officers. Officer A fired one round at Subject 1, striking Subject 1. Subject 1 threw his gun over the railing of the walkway and fell to the ground. Subject 2 then moved toward Officer A, yelling that Officer A had shot his/her brother. Officer A observed Subject 2's hand grab the top of Officer A's service pistol. Officer A told the others that Subject 2 was going for Officer A's service pistol. Officer A pulled his service pistol downward and away from Subject 2. Officer B moved up behind Officer A and prepared to fire a "contact shot" at Subject 2. However, the Special Agent and Officer D were able to pull Subject 2 away and take him into custody. Subject 1 later died as a result of his injury.

Officer A looked down and saw that the magazine from his service pistol was on the ground. Officer A retrieved the magazine and re-inserted it into the pistol.

The COP found that Officer A through E's tactics were seriously deficient, requiring AD.

The COP noted that once Officer E was advised that the Officers were at Subject 1's address, Officer E should have instructed the officers to notify an on-duty supervisor who could have responded to the scene. The COP noted that Officers A, B and C did not have the proper equipment with them, including binoculars. The COP would have preferred that Officers A and B had met the Special Agent and Officer D at an off-site location instead of in front of the Subject's apartment building. The COP also would have preferred that Officer A and/or Officer B had been equipped with a radio when they approached the Subjects' location instead of limiting their communications with Officer C to the use of cellular telephones. The COP also would have preferred that prior to approaching the subjects' location, the Officers had requested additional units, set up containment around the location, and were attired in body armor and raid jackets. The COP would have preferred that Officer B had advised the other officers and the Special Agent of Officer B's decision to deviate from their original plan. The COP also found that Officer E's lack of control and the Officers' actions unnecessarily placed the Officers in a tactically disadvantageous situation.

The COP found Officers A, B, and D's drawing and exhibiting of a firearm to be in policy because at the time Officers A, B and D drew their pistols, they had sufficient information to believe the situation may escalate to the point where deadly force may become necessary.

The COP found Officers A, B, and D's non-lethal use of force to be in policy, as their non-lethal use of force was reasonable to overcome the Subjects' resistance and control them.

The COP found Officer A's lethal use of force to be in policy because, at the time Officer A fired at Subject 1, it was reasonable for Officer A to believe Subject 1 presented an immediate threat of serious bodily injury or death.

The Commission adopted the COP's recommendations.

The Department's Revised Table L indicated that the corresponding complaint number for OIS No. 05-061 was CF No. 05-5457. However, according to information we received from IAG's Administrative Records Section, CF No. 05-5457 was consolidated with CF No. 06-2937. In CF No. 06-2937, one allegation each was framed against Officers A through E for Unauthorized Tactics. Each allegation was Sustained, and each Officer received an Admonishment with the exception of Officer B, who received an Official Reprimand. The OIG believes that, with the exception of Officer B, these penalties were appropriate. However, the OIG believes that the lack of oversight demonstrated by this long-tenured supervisor, which the adjudicator of the complaint recognized put all involved Officers in a "tactically disadvantaged situation," merited a stronger penalty for Officer B.

OIS No. 05-030

Subject 1 called the residence of off-duty Officer A, asking for Officer A's nephew who had been staying with the Officer's family. Officer A responded that his/her nephew was not home. The caller then requested to speak to another person. At this time, Officer A inquired who was calling and the suspect responded angrily, cursing at Officer A. Officer A hung up. Within seconds, the caller called again demanding to know why she was hung up on and demanding to know who was on the telephone. Subject 1 continued to curse and to verbally abuse Officer A. Again, Officer A hung up. Subject 1 called again. This time, Officer A had his/her spouse

answer the telephone. Subject 1 then became verbally abusive to the spouse. The call concluded with the spouse's comment "You're a b**ch." Almost immediately, the telephone rang again. Officer A picked up the telephone and hung it up without answering. The telephone rang again, and Officer A picked it up and immediately hung it up.

Subject 1 again called and threatened the spouse. According to the spouse, Subject 1 stated that she knew where they lived and Subject 1 threatened to come to the house with friends to "f**k up" the spouse. Officer A did not consider the threat from the unknown caller to be credible. There was an additional telephone call from the same caller that went directly to an answering machine. The recorded message stated: "Who's laughing now, scaredy-cat?"

Approximately 45 minutes after the first phone call, the spouse heard a disturbance outside. Looking outside, the spouse observed two males and two females in the street directly outside the residence. The spouse observed one of the females make a throwing motion that appeared aimed at Officer A's vehicle. Officer A heard the spouse shout that someone was out front. The spouse told Officer A the people outside were vandalizing the family vehicle.

Officer A retrieved his/her service pistol from its holster located in his duffel bag in the room where he/she was watching television. Officer A proceeded outside to confront the individuals in the street. At this time he/she was carrying the weapon down to his/her side. As he/she left the house, he/she instructed the spouse to call the police. Officer A was attired in sweatpants and a blue shirt with no markings or identification to suggest that Officer A was a law enforcement officer and carried no equipment other than his/her service pistol. While Officer A retrieved his/her pistol, he/she did not retrieve either his/her badge or police officer identification. When addressing the group, Officer A did not identify himself/herself as an off-duty police officer.

With his/her pistol held alongside his/her leg, Officer A moved across the front lawn of the residence to obtain a view of the individuals in the street. Officer A addressed the group, instructing them to keep their distance.

When members of the group observed Officer A with his/her pistol, three of the group moved to the opposite side of the street. Remaining across the street from the group, Officer A directed the spouse to return to the residence and to call the police. Subject 1 grew verbally abusive, taunting Officer A and the spouse about calling the police. Once inside the residence, the spouse instructed another nephew to call 911. The spouse then returned to the street, where the spouse heard Subject 1 state that she had family in the Mexican Mafia and further threaten Officer A. Subject 1 walked to the spouse challenging him/her to fight. Officer A attempted to push Subject 1 away from the spouse, but Subject 1 reached out and grabbed the front of the spouse's shirt. The spouse, in response, pushed Subject 1 away.

Subject 1 walked back to the curb, reached down and picked up an object, and circled around her friends to the front lawn of the residence across the street from Officer A's residence. Both Officer A and the spouse remained in the street when Subject 1, making a stabbing style motion with the object in her hand, began to advance on Officer A and the spouse. When the spouse observed the object in Subject 1's hand, the spouse warned: "She has a knife."

As Subject 1 advanced toward Officer A and the spouse with what they perceived to be a knife, Officer A fired a single "warning shot" into the lawn between Subject 1 and the three individuals who accompanied her to the location. The round struck the lawn approximately 25 feet away.

The item that was perceived by Officer A and the spouse to be a knife was subsequently determined to be a dinner fork that Subject 1 had brought to the scene. Several witnesses described the object as ranging from a "metal object" to a fork.

Subject 1 fled the scene to the back residence of the nearby home. She walked into that residence through an unlocked door, surprising the 14-year-old male occupant who was in the residence playing video games. Subject 1 then used the telephone in that back residence to call 911. Meanwhile, the mother of the teenager heard the gunshot and attempted to call 911, but could not get through. The mother went to check on her son and found Subject 1 there with her son on the telephone with the 911 operator. When the local law enforcement agency arrived, the mother escorted Subject 1 to the front door of her residence to meet the officers. The local law enforcement spoke to Subject 1 and took her into custody.

Officer A then identified himself/herself as a Los Angeles Police Department officer. He/she placed his service pistol on the ground and was handcuffed pending a preliminary investigation. Officer A, and Subject 1's three friends who were also taken into custody, were later released. Subject 1 remained in custody, and was later convicted of one count of making criminal threats.

The COP found Officer A's tactics seriously deficient, warranting an AD finding because, when Officer A received several telephone calls of a threatening nature and was alerted by the spouse that someone was throwing objects at their vehicle, Officer A ignored those early warning signs and threats. Officer A failed to give clear direction to his/her family to remain in the residence where they would be safe and to ensure that the local police were notified. The COP also noted that Officer A armed himself/herself with his/her personally owned pistol, drawing it from a nylon holster, and left the holster in his residence. Officer A elected to confront the Subjects, who were possibly committing a property crime, in front of his/her house. Officer A's decisions left him/her with few tactical options and placed him at a tactical disadvantage because he/she did not have the equipment items an on-duty officer would routinely have such as a uniform, identification card, radio, body armor, handcuffs, baton, Oleoresin Capsicum spray, etc. Further, the COP noted that as Officer A exited his/her residence, there was no urgency to confront the Subjects. The Subjects were at most committing a property crime which posed no immediate threat to Officer A. The COP would have preferred that Officer A had remained inside and instead notified local law enforcement. The COP was also concerned that when Officer A exited the residence, the spouse accompanied him/her outside. The COP noted that as Officer A confronted the Subjects, he/she did not adequately utilize cover afforded to him/her such as the vehicle, but stepped into the middle of the street while attempting to verbalize with the Subjects. The COP also noted that Officer A did not maintain distance from the subjects and did not identify himself/herself as a police officer, which may have diffused the situation.

The COP determined that Officer A's deficient tactics unnecessarily placed himself/herself and his/her family at risk of injury. The COP noted that while the law is specific in recognizing that an officer does not have to retreat and is not considered the aggressor when dealing with

criminals, confronting subjects without the benefit of sufficient backup, tactical equipment and communications constitutes poor tactics.

The COP also found Officer A's drawing, exhibiting and holstering to be out of policy, warranting an AD finding. The COP noted that Officer A exited his/her residence with an unholstered pistol to confront the subjects. The lack of a holster as well as his/her attire (sweatpants and a t-shirt), precluded Officer A from having the ability to secure his/her pistol. The COP further noted that when Subject 1 approached and physically assaulted the spouse, Officer A placed his/her pistol close to his/her body as he/she utilized his/her free hand to push Subject 1 away. The COP considered Officer A's tactical and use of force options to be severely limited as the incident unfolded. Further, the COP determined that when Officer A unholstered the firearm inside his/her residence, there was no threat which would have reasonably led him/her to believe that a deadly force situation may occur. In addition, the decision of Officer A to unholster the pistol was premature as, at that time, the subjects posed no immediate threat, and his/her decision to unholstered his/her weapon limited his/her tactical and use of force options.

The COP found Officer A's use of lethal force, a "warning shot," to be in policy, but warranted formal training. The COP considered that the spouse alerted Officer A that Subject 1 was armed with a knife. Officer A then focused his/her attention on Subject 1 and observed a metallic object, which he/she believed to be a knife, in Subject 1's hand. Officer A ordered Subject 1 to drop the weapon but she failed to comply and advanced toward Officer A and the spouse while making overhand stabbing motions. The COP noted that Officer A, believing Subject 1 posed an immediate threat to them and in an effort to dissuade Subject 1 from further aggressive action and prevent the situation from escalating to the point where lethal force was necessary, opted to fire a single "warning shot" from a distance of approximately 25 feet. Officer A fired the "warning shot" in a downward direction into the grassy area near where Subject 1 was standing. When Officer A fired the "warning shot," he/she was aware there was a residence with a large plate glass window behind Subject 1.

The COP noted that although "warning shots" are generally prohibited, in this incident it was reasonable for Officer A to believe that Subject 1 posed an immediate threat of serious bodily injury or death. As a result of firing the "warning shot," Subject 1 stopped her advance and ran away. The COP found that it is likely that Officer A's decision to fire a "warning shot" prevented him/her from having to use lethal force on Subject 1.

The Commission adopted all of the COP's recommendations.

A complaint investigation regarding Officer A's actions was initiated on the day that the incident occurred, CF No. 06-0878. This investigation resulted in two allegations that the Officer's Tactics and Drawing/Exhibiting/Holstering were Administratively Disapproved. These allegations were Sustained, and the officer received an Official Reprimand as well as a referral to training. The OIG believes that the penalty and referral to training were appropriate, in light of the Officer's lack of any prior Sustained complaints of a similar nature and the dangerous and rapidly unfolding situation which confronted his/her family.

ND No. 05-115

Officer A was in a police station parking lot conducting an inspection of his/her assigned vehicle. After the vehicle inspection was completed, Officer A retrieved his/her back-up weapon, a .38 caliber revolver, from his/her back pocket to clean. The Officer opened the pistol cylinder and believed he/she unloaded all five rounds. When the cleaning was finished, the Officer closed the cylinder, assumed a right-handed firing position, pointed the pistol at the ground and pulled the trigger. The pistol discharged a round into the parking lot of the police station.

The COP found Officer A's use of force to be negligent, warranting an AD finding. Further, the COP directed Officer A to additional firearms training at TD.

The COP was critical that Officer A failed to adhere to the basic firearm safety rules while handling his/her backup weapon. Officer A did not utilize the Loading/Unloading Barrel and failed to visually inspect the weapon prior to closing the cylinder and pressing the trigger. The COP was also concerned that Officer A elected to clean his/her weapon in the parking lot, near the rear of his/her police vehicle.

The Commission concurred with the COP's recommendations.

A complaint investigation regarding Officer A's actions was initiated on the day that the incident occurred, CF No. 06-0091. This investigation alleged that Officer A, while on duty, negligently handled his/her back-up firearm resulting in an accidental discharge. This allegation was Sustained, and Officer A received an Official Reprimand as well as formal tactical training. The OIG believes that the penalty and the referral to training were appropriate in light of the fact that the employee had no prior Sustained complaints of a similar nature.

ND No. 05-074

Officer A completed taking part in a weapons inspection in the patio area behind the Ahmanson Recruit Training Center (ARTC). After the inspection, Officer A chambered a round into his/her service pistol from a full magazine of 15 rounds he/she had seated into the pistol magazine well. When Officer A did this, he/she failed to engage the safety on the pistol. When Officer A was preparing to re-holster the pistol, an accidental discharge occurred. Officer A stated that he/she did not recall his/her finger being on the trigger of the pistol when the discharge occurred. At the time, four other officers were in the patio area, but they did not witness the discharge. Each indicated that they heard a round discharge, turned, and observed Officer A holding the pistol in his/her right hand pointed toward the ground. The direction the round was fired in was not in the same direction of any of the other occupants on the patio at the time of the discharge.

The COP noted that when Officer A chambered a round, he/she did not use one of three loading/unloading barrels located in close proximity to the location where he/she chambered a round in the weapon. The COP was also concerned that Officer A did not adhere to basic firearm safety rules when handling his/her service pistol. The COP noted that a negligent discharge is a serious incident and could not be mitigated.

The COP found that Officer A's use of force was negligent, requiring an AD finding. The COP directed the Officer's CO to schedule Officer A for additional firearms training at TD.

The Commission adopted the COP's recommendations in this case.

The complaint investigation related to this incident, CF No. 05-1568, resulted in one allegation that the Officer's use of force was Administratively Disapproved. This allegation was ultimately adjudicated Out of Statute. Thus, pursuant to State law, no penalty was imposed upon Officer A. Per information we received from the Department, this complaint fell Out of Statute due to an oversight by a member of the Department's Use of Force Division in not timely initiating a personnel complaint regarding this specific AD finding. However, we have also been informed that monthly audits have since been initiated to avoid a future recurrence. Moreover, Officer A did receive remedial firearms training shortly after the incident.

LERI No. 06-011

Officer A and Officer B were assigned to a uniformed crime suppression detail. While driving westbound, Officer B observed Subject 1 riding a bicycle in the opposite direction without a forward facing lighting device during the hours of darkness, a violation of the California Vehicle Code. They decided to stop Subject 1 for the violation. Officer B then negotiated a U-turn and positioned their police car behind Subject 1; however, Subject 1 did not stop. Rather, Subject 1 increased his speed while holding the handlebars of the bicycle with his left hand and manipulating an object in his right front pants pocket with his right hand. Officers A and Officer B discussed the possibility that Subject 1 was armed with a handgun or in possession of narcotics. When Officer B followed Subject 1 and pulled the car approximately five feet behind Subject 1, Officer A, while in the passenger seat, ordered Subject 1 to stop. Subject 1 ignored these commands and continued to ride eastbound, causing Officer B to activate the emergency equipment of the police vehicle.

Subject 1 made a southbound turn, turned into a driveway, and then rode his bicycle northbound on the sidewalk. When Officer B stopped the police car near the mouth of the driveway, Officer A, who did not advise his/her partner of his/her intentions or equip himself/ herself with a baton, exited and ran northbound on the roadway "to cut off [Subject 1's] escape route."

Officer A ran past Subject 1 and then ran westbound onto the sidewalk. Believing that Subject 1 was armed, Officer B exited the police car, drew his/her service pistol, and assumed the role of "cover officer." While moving toward Subject 1, Officer A observed the outline of a handgun in Subject 1's front right pants pocket and noted that he was attempting to retrieve it. According to Officer A, Subject 1 was unable to retrieve the handgun because the "trigger guard or something was caught in his pants pocket"

Officer A used his/her hands to "push [Subject 1] against a wall hard enough to cause [Subject 1] fall off the bike." Subject 1 immediately stood up and ran toward Officer B, effectively placing himself between the two officers. Officer A approached Subject 1 and pushed him on his back, causing Subject 1 to fall into a prone position. Officer A then approached Subject 1, placed one knee on Subject 1's upper back, and ordered Subject 1 to extend his hands from his body and not to move. When Subject 1 complied, Officer A observed the butt of a handgun extending from Subject 1's right front pants pocket. While atop Subject 1's back, Officer A drew his/her service weapon and pointed it within two inches of Subject 1's head and upper torso so that he/she could affect a "contact shot" if necessary while Officer B approached them as a "cover officer."

Officer B holstered his/her service pistol, and recovered a loaded handgun from Subject 1's right side. Officer B handcuffed Subject 1 without further incident. During this time, Subject 1 complained of injuries to his left arm and informed the officers that his arm was broken. A rescue ambulance (RA) later treated Subject 1 for a possible fracture of his left arm and transported him to the hospital where he was admitted for surgery.

The COP determined that Officers A and B's tactics were seriously deficient and requiring an AD finding. The COP directed the CO to schedule the Officers for training at TD.

The COP also noted that upon recognizing the Officers, Subject 1 began to pedal faster. Officer B negotiated a U-turn and began to close in on Subject 1. The Officers observed Subject 1 riding his bicycle with his left hand on the handlebar and his right hand manipulating something in his right front pants pocket. The Officers communicated their observations to each other and formed the opinion Subject 1 might be in possession of narcotics or a handgun. The COP believed that it would have been tactically safer for Officer A to advise Communications Division (CD) of their status and location and to request a back-up unit. The COP further noted that additional resources would have provided necessary personnel and force options to best resolve the incident. Additionally, the COP indicated that Officer A should have broadcast the Subject's description, direction of travel and that the Subject was riding a bicycle.

The COP further noted that Officer B drove up approximately five feet behind the Subject, and Officer A verbally directed the potentially armed subject to stop while they were still seated in the police vehicle. The COP noted that it would have been tactically safer for the Officers to utilize the vehicle's PA system along with the emergency equipment to exert their authority to direct the Subject to stop while also maintaining a safe distance.

The COP also noted that Officer A was not in possession of his/her baton when exiting the police vehicle and running northbound on the roadway in an attempt to cut off Subject 1. The COP indicated that it would have been tactically safer for the Officers to establish a pre-planned tactic to apprehend the Subject in these circumstances before spontaneously exiting the police vehicle. Officer B, the designated cover officer, exited the vehicle, drew his/her pistol and moved to the front of a parked vehicle adjacent to the curb. The COP noted that although Officer B obtained cover, he/she was a considerable distance from his/her partner and could not effectively provide cover. The COP further noted that Officer B's position also placed himself/herself and his/her partner at a tactical disadvantage with the potential for a crossfire situation.

Officer A overcame Subject 1 and was standing on the roadway as Subject 1 was riding his bicycle northbound on the west sidewalk. Officer A observed Subject 1 reaching into his right front pocket for what appeared to be the silhouette of a handgun. The COP noted that rather than move to a position of cover and draw his/her service pistol, Officer A extended his/her arms and with open hands pushed Subject 1's upper torso toward the east wall. Subject 1 collided into the wall, causing him to fall off his bicycle and onto the sidewalk. The fall caused Subject 1 to remove his right hand from the area of his right front pants pocket. Subject 1 immediately stood up and attempted to run southbound away from Officer A. Officer A again pushed Subject 1 with both hands on the upper back, causing Subject 1 to fall in a prone position. Officer A approached Subject 1 and placed his/her right knee on Subject 1's upper back and ordered him to

hold his hands out to his sides and not to move. At this time, the butt of the handgun was protruding out of Subject 1's right front pants pocket.

Officer B approached and, while continuing to cover Subject 1, told Officer A he/she was going to remove the handgun. Seeing the gun, the COP noted that it would have been tactically sound for Officer A to have remained the contact officer throughout the incident as he/she was in a position of control.

The COP found Officer A's drawing and exhibition of a firearm in policy, requiring no action. The COP determined that Officer A had sufficient information to believe the situation may escalate to the point where deadly force may become necessary. However, the COP directed the CO to schedule Officer A for training at TD. The COP noted Officer A drew his/her service pistol while in a kneeling position with his/her bodyweight positioned on Subject 1's back. The COP believed that this tactic was unsound and unsafe and noted that officers are trained to avoid drawing their pistol while in contact with a subject to avoid the subject reaching for the weapon or the possibility of a negligent discharge of the firearm.

The COP found Officer B's drawing in policy, requiring no action. The COP noted that Officer B was the cover for Officer A and that he/she drew his/her service pistol when he/she exited the police vehicle. The COP determined that Officer B had sufficient information to believe the situation may escalate to the point where deadly force may become necessary.

The COP found Officer B's non-lethal use of force in policy requiring no action.

The COP noted that Officer A overcame Subject 1 and was standing on the roadway as Subject 1 was riding his bicycle northbound on the sidewalk. Officer A observed Subject 1 reaching into his right front pocket for what appeared to be the silhouette of a handgun. The COP also noted that, rather than move to a position of cover and draw his/her service pistol, Officer A extended his/her arms and with open hands pushed Subject 1's upper torso toward the east wall, causing Subject 1 to collide into the wall and fall off his bicycle onto the sidewalk. Subject 1 immediately stood up and attempted to run southbound away from Officer A. Officer A again pushed Subject 1 with both hands on the upper back, causing Subject 1 to fall in a prone position. Officer A approached Subject 1 and placed his right knee on Subject 1's upper back and ordered him to hold his hands out to his sides and not to move. The COP determined that Officer A's non-lethal use of force was reasonable to overcome Subject 1's resistance and to effect his arrest.

The Commission adopted the COP's recommendations.

A complaint investigation regarding Officer A and B's actions was initiated on the day that the incident occurred, CF No. 06-5649. Allegations were framed against Officers A and B for Unauthorized Tactics, which were Sustained. Each received an Admonishment as well as formal tactical training. The OIG believes that the penalty and the referral to training were appropriate given that neither Officer had a significant Sustained complaint history for similar misconduct.

LERI No. 05-046

In the early morning, Officers A and B were patrolling in a marked police vehicle. Officer A saw a male juvenile (Subject 1) walking in the street, and drove the police vehicle past Subject 1.

Officer A watched Subject 1 in his/her rear view mirror, to "see what he was going to do." The Officers observed Subject 1 to look too young to be out at that time. Officer A negotiated a U-turn to drive back towards Subject in order to conduct a pedestrian stop.

Officer A told Subject 1, who had his hands in his pockets, to "stop right there." Subject 1 stopped and replied, "for what?" Officer A told Subject 1, "turn around and take your hands out of your pockets." Subject 1 replied, "for what?" Officer A repeated his instruction and Subject 1 complied, turning and placing his hands behind his back. Officer A asked Subject 1 how old he was, and Subject 1 replied that he was eighteen. Officer A conducted a "pat-down" search of Subject 1, recovering a pocketknife and a folding multi-tool.

Officer B returned to the police vehicle and conducted a check on the information provided by Subject 1. The check yielded no matches. Officer B returned to Subject 1 and again asked for his name and date of birth. Subject 1 provided the same information. Officer B conducted further checks. None of these checks yielded any matches.

Officer B told Officer A that Subject 1 did not "have any identification in the system." Subject 1 then stepped back to a dirt path that ran parallel to the sidewalk. Subject 1 then began to run eastbound on the path, away from the Officers. Officer A went into foot pursuit of Subject 1 along the dirt path. Officer B followed by running eastbound on the sidewalk, paralleling the foot pursuit. Neither Officer broadcast that they were in foot pursuit. According to Officer B, he/she attempted to use his/her radio but was unable to take the radio from its holder on his/her equipment belt. Officers A and B were both holding flashlights as they pursued Subject 1.

The foot pursuit continued for a distance of approximately 150 feet, at which point Officer A physically contacted Subject 1, still holding his/her flashlight as he/she did so. Subject 1 went to the ground, where Officer A restrained him. During this stage of the incident, Subject 1 sustained a 1½-inch laceration to his scalp and a 3-inch bruise to the right side of his back.

According to Subject 1, as he ran away from the Officers he was struck in the back of the head. Subject 1 then stumbled. Subject 1 also stated that, after being hit in the head and stumbling, he felt a second blow to his back, at which time he fell, landing face-down to the ground.

According to Officer A, as he/she caught up with the fleeing Subject 1, he/she placed his/her left hand over Subject 1's left shoulder and used his/her right hand (still holding the flashlight) to reach over Subject 1's right shoulder. Subject 1 then tripped on the raised lip of a concrete path that crossed the dirt path, causing Subject 1 to fall. As Subject 1 fell, Officer A was about to grab him. The momentum of Subject 1 falling caused Officer A to fall on top of Subject 1, landing on top of Subject 1's upper torso. Officer A stated that he/she never lost control of his/her flashlight throughout the fall and that when he/she landed, his/her right hand was at Subject 1's right shoulder. Officer A stated that his/her flashlight had "eventually contacted . . . the top of Subject 1's head," but denied intentionally striking him. According to Officer A, the flashlight contacted Subject 1's head as Officer A brought his/her right hand over Subject 1's shoulder. Officer A stated that he/she held his/her flashlight by the bulb-end (as opposed to the handle), and that when he/she landed, his/her hand was at Subject 1's shoulder. Officer A denied striking Subject 1 in the back with his/her flashlight.

An expert in injury pattern analysis opined that Subject 1's head laceration was "most consistent with being struck with an object," and that, "the bruise on the back is a pattern bruise consistent with the outline of the handle of [Officer A's] flashlight." The expert further opined that the "most logical explanation f[or the bruise to Subject 1's back] is that the officer either struck him from the left side, i.e., the officer had the flashlight in [his/her] left hand and was to the side of [Subject 1] and hit him in such a way to leave a clear pattern bruise or if the officer fell on top of [Subject 1] trapping [his/her] flashlight between [him/her] and [Subject 1], this could account for the sharp outline of the bruise." The expert concluded that, "it is most likely that the head laceration occurred when [Subject 1] was struck by an object from behind and that the pattern bruise occurred when the officer fell on top of [Subject 1]."

Once on the ground, Subject 1 offered no further resistance and was handcuffed. As the officers walked Subject 1 back towards the police vehicle, Subject 1 complained of pain to his head. Officer B saw that Subject 1's head was bleeding. Subject 1 provided Officer B with his true name and date of birth. A check revealed that Subject 1 had an outstanding felony warrant.

The COP noted that Officer A negotiated a U-turn, proceeded to cross the eastbound lanes of traffic, and stopped the police vehicle adjacent to Subject 1. Officer B notified CD of their location. The COP would have preferred that Officers A and B had approached Subject 1 from behind and parked the police vehicle with the flow of traffic. Due to the Subject's initial refusal to cooperate and the property recovered from him, the COP would have preferred the Officers had handcuffed him.

The COP noted that neither of the Officers broadcast that they were in foot pursuit, which covered a distance of approximately 150 feet. The COP found that, as the foot pursuit continued, Officer A's flashlight began to fall out of his/her right sap pocket. Officer A grabbed the flashlight with his/her right hand (gun hand) and continued chasing Subject 1. The COP found that Officer A secured his/her flashlight in his/her gun side sap pocket and that Officer A held his/her flashlight in his/her gun hand. The COP noted that, had the incident escalated to a shooting situation, Officer A would have been delayed in transitioning to his/her service pistol.

The COP noted that, as Officer A caught up to Subject 1, he/she attempted to grab Subject 1 in a "bear hug" by wrapping his/her arms around Subject 1's shoulders. The COP was critical of Officer A's decision to attempt a takedown while in possession of his/her flashlight, noting that by contacting the Subject while still holding his/her flashlight, Officer A unnecessarily increased the potential for injury to the Subject. The COP noted that Officer A should have secured the flashlight prior to contacting the Subject, and that, at the point Officer A decided to contact the suspect, he/she could have secured his/her flashlight in his/her sap pocket. The COP determined that Officers A's tactics were seriously deficient and required AD. The COP also directed the CO for the area to schedule Officer A for formal training at TD.

The COP determined that Officer B would benefit from divisional training and directed the CO to provide and document the appropriate training for Officer B.

The COP found Officer A's non-lethal use of force in policy, requiring no action.

The Commission adopted the recommendations of the COP.

In the related complaint investigation, CF No. 06-0654, one allegation of Unauthorized Tactics was Sustained against Officer A who received a two-day suspension. The OIG believes that the penalty was appropriate, given the Commission's finding that Officer A unintentionally struck the subject with a flashlight and given Officers A's lack of prior similar complaints.

LERI No. 05-101

In response to a homicide believed to have involved gang members, Officers A, a supervisor, and Officers B - H proceeded to the home of Subject 1, a known gang member. The Officers were advised that Subject 1 was on probation for a weapons violation. Officers were further advised that there was an outstanding arrest warrant for Subject 1. Officer B stated that he/she informed the team that Subject 1 had been arrested previously for possession of a rifle. Officer D stated that he/she believed that Subject 1 had been arrested previously for possession of a shotgun.

Officers G and H were assigned to cover the rear of the home, while other officers approached the front. Officer D observed a male with a shaved head (later identified as Subject 1) walking southbound near the residence.

According to Officer D, he/she shone his/her flashlight on Subject 1, who then turned and ran northbound. Officer D advised the other officers that "we have a runner running northbound." The officers asked the occupants to exit the residence. The Officers were then directed by Officer A to enter the home to conduct a search.

Officers E and G drew their service pistols and searched the interior of the house looking for Subject 1, but were unable to locate him. Inside a bedroom, Officer E located an opening to the attic, which was partially covered by a lid. This opening was inside a closet within the bedroom.

Officer A indicated that he/she requested that the attic be cleared. Officer C then stuck his/her head into the attic, but was unable to see a small portion of the attic.

Officer C entered the attic through the opening in order to "clear" the attic. Once inside the attic, Officer C saw Subject 1 crouched along the north wall of the attic. Officer C then drew his/her service pistol and took a crouching position west of the attic opening. Officer C noticed that Subject 1 had his hand in his waistband, which, in conjunction with Subject 1's prior weapons possession charge and Officer C's understanding that it is common for gang members to hide weapons in the waistband area, caused Officer C to believe that Subject 1 was armed. Officer C asked Officer E to enter the attic to assist. Officer E drew his/her service pistol, and on the attic floor. Officer D then stood on the dresser. Officer C noticed that Subject 1 had his right hand inside his waistband. Subject 1 was ordered to remove his hand, but refused to comply. Instead, Subject 1 made several comments to the officer, indicating that Subject 1 and the Officers would not make it out of the attic alive.

Officer C then requested a beanbag projectile shotgun. The request was relayed by Officer F, who was inside the bedroom, to Officer A, who was outside the house. A beanbag shotgun request was broadcast and overheard by Officers I and J. This caused Officers I and J to respond to the scene to assist, even though they were not equipped with a beanbag shotgun. Eventually, Officer A delivered the beanbag shotgun to Officer D.

The officers made “deals” with Subject 1, offering him the opportunity to talk to his father if Subject 1 would show the officers his hands. This did not work, and Officer A moved the family members away to a Command Post location for their safety.

Flashlights were brought into the attic to help illuminate Subject 1. Officer C warned Subject 1 about the potential use of the beanbag shotgun should he continue to refuse to comply. According to Officer D, Officer A gave the order that if Officer C believed that using the beanbag shotgun was necessary, Officer D should use the beanbag shotgun. Officer C instructed Officer D to fire if he/she could get a good shot.

When Subject 1 refused another order to show officers his hands, Officer D fired one beanbag round at Subject 1. Officer D believed that this round hit Subject 1 in his wrist. Subject 1 stated that two rounds were fired at this point, one hitting him on the arm and another on the neck.

According to Officer D, Officers took turns giving Subject 1 commands to show his hands. When Subject 1 refused to comply, additional beanbag warnings were given. Officer D stated that he/she was given additional orders to fire, and Officer D continued to fire beanbag rounds at Subject 1, assessing the situation and giving warnings between each shot fired. Officer A requested K-9 and other officers to respond stand by.

According to Officer E, as the Officers approached Subject 1, he again became agitated and moved west. Subject 1 was warned that the TASER was going to be used. Believing that Subject 1 may be going for his waistband to reach a weapon, Officer E decided to deploy his/her TASER, which was unsuccessful.

At about this time, Officers K - N arrived. The officers conducted a briefing with higher-ranking Officers O, P, and Q and formulated a tactical plan. Four officers then entered the bedroom and advised Officers C, D, and E to exit the attic to be relieved by the other officers.

Officer K moved to within 10-15 feet of Subject 1 and noticed that Subject 1 continued to place his hands “in and out.” Officer K continued to give commands to Subject 1, ordering him to proceed towards the officers, show his hands, and submit to arrest. However, according to Officer K, Subject 1 continued to act in the same fashion and as such, Officer K warned Subject 1 that he/she would use a TASER on him. Subject 1 made threats towards the officers, stating that he had a gun, that he was not going to go to jail, and that he was going to kill the officers. In response to Subject 1's threats and continued movements, Officer K deployed his/her TASER, which hit Subject 1 and discharged for a pre-set interval of five seconds.

Officer K continued to order Subject 1 to move out where he could be taken into custody. However, Subject 1 continued to thrash around and try to move back into the area where he could not be reached. Officer K pressed the TASER trigger once again, sending another five second charge into Subject 1's body. According to Officer K, at this time, Subject 1 submitted to arrest and was handcuffed by Officer N. Subject 1 sustained multiple contusions and abrasions to his chest, arms, legs, wrists, and neck. Subject 1 was booked for a warrant.

A search of the attic revealed no weapons. According to the Department, Officers were in the attic for approximately one hour and 40 minutes.

This was initially classified as a Non-Categorical Use of Force. When it was later determined that Subject 1 was going to be hospitalized for neck swelling he sustained from an impact from a beanbag projectile, the investigation was assumed by Force Investigation Division.

The investigation revealed that a total of 26 beanbag rounds were fired at Subject 1 inside the attic. Subject 1 was struck by at least 11 beanbag rounds as well as pellets from a beanbag round. One round hit Subject 1's chest, one hit his abdomen, and two hit Subject 1 in the neck. The remaining seven rounds struck Subject 1 in the extremities. Additionally, based upon Subject 1's injuries, it appears that at least one of the beanbag rounds hit an intermediary target and burst open, causing the pellets themselves to strike Subject 1's left arm.

The COP noted that under the direction and supervision of Officer A, the assigned personnel went to Subject 1's residence to perform a probation search with the knowledge that he had an outstanding felony arrest warrant for possession of a concealed weapon. This should have been handled as an arrest warrant service, which required that a Warrant Service/Tactical Plan Report be completed. This would have ensured that specific protocols were followed and would have facilitated a safer and more efficient tactical operation.

The COP further noted that as the Officers deployed around the residence, Officer D assumed a position to the rear of the location and remained alone until he/she announced that he/she observed Subject 1, who was at the time unidentified, running from him. At this time, Officer C responded to the rear to assist Officer D. The COP determined that it would have been tactically safer for Officers D and C to remain together to perform rear containment of the residence.

The COP also noted that after it was determined that the fleeing individual had run inside the residence, Officer A and the other Officers should have recognized the circumstances were consistent with the criteria for a barricaded suspect. At that point, the Officers should have contained the location and notified the division for advice. This would have allowed other officers an opportunity to determine if it was appropriate for them to respond and assume tactical oversight of the incident.

The COP noted that after Officer A decided to utilize his/her personnel to initiate a search of the residence, they discovered that the cover to the attic was partially ajar but again elected not to establish containment or to make appropriate notifications to the division. They opted instead to search the attic, with Officer C entering the attic and confronting Subject 1.

The COP further noted that, once again, Officer A and the officers elected not to contain Subject 1 and, instead, began a long face-to-face standoff with no cover. The standoff resulted in numerous super-sock rounds and a TASER being utilized in an attempt to get Subject 1 to submit to arrest. Officer A did ultimately contact the division and was advised that the incident met the criteria of a barricaded suspect and that other specially trained officers would respond.

The COP noted that Officer D stood in the opening of the attic with his/her upper torso exposed to Subject 1 and fired numerous super-sock rounds. After the final round, he/she held the beanbag projectile shotgun in his/her right hand while holding the TASER in his/her left hand as he/she attempted to gain compliance by activating the TASER's laser sight on Subject 1. Officer D also maintained a Department-approved shotgun lying on the attic floor directly in front of

him/her as he/she deployed the beanbag projectile shotgun. The COP noted that it would have been tactically safer for Officer D to deploy only one weapon at a time. In addition, there was no Combative Suspect Control Team (CSCT)¹² designated or a plan in place to detain Subject 1 if either the beanbag shotgun or TASER had been ineffective in causing him to surrender.

The COP noted that for a significant length of time during the standoff, the other occupants of the residence were allowed to remain inside instead of being evacuated for their safety. The COP determined that it would have been tactically safer for the occupants to be evacuated until Subject 1 was apprehended.

The COP further determined that, although Officer A was tasked with many responsibilities as this incident unfolded, his/her primary responsibility should have been to remain with the Officers inside the residence as they initiated their plan to confront and detain Subject 1.

The COP noted that although Officer A was advised by the division that the incident met the criteria of a barricaded suspect and that other personnel were responding, he/she proceeded to direct the use of the beanbag shotgun. The circumstances warranted establishing containment and did not present the exigency to fire the beanbag shotgun to gain compliance while awaiting the response of other personnel.

The COP further noted that after Officers C and E entered the attic, Officer D stood in the opening of the attic with his/her upper torso exposed to Subject 1. Subject 1 repeatedly refused to comply while continuing to place his hand inside of his front waistband area. Officer A then directed that the beanbag shotgun be utilized to gain compliance from Subject 1. Officer D was handed a beanbag shotgun and placed it onto the floor directly in front of him. Officer D then fired a total of 26 super-sock rounds at Subject 1 from a distance of approximately 35-37 feet. Officer D provided a verbal warning prior to each round and assessed after each round fired. The COP determined that Officer D should have recognized that the beanbag shotgun was not effective in obtaining Subject 1's compliance prior to firing a total of 26 rounds.

The COP also noted that Subject 1 moved around often while in the attic and at one point began to come toward the Officers as if to surrender, but then retreated. Officer E then fired one cartridge from the TASER at Subject 1 from a distance of five to eight feet. Officer E believed that one TASER dart struck Subject 1 and the other dart struck a wooden portion of the attic. Subject 1 was not affected by the TASER and continued his refusal to comply.

The COP was critical of Officers D and E's decision to utilize the beanbag shotgun and TASER, respectively, to attempt to gain compliance from Subject 1 after being informed that other personnel were responding. The COP would have preferred that the Officers, once in their position within the attic, had continued to contain Subject 1 and not utilized force unless necessary, pending the arrival of other officers.

The COP was critical of Officer A's direction to utilize the beanbag shotgun to gain compliance from Subject 1 after he/she had been advised that other officers were responding.

¹² The CSCT is a separate team of officers put in place during the time the other officers are deploying the TASER who will maintain control of the subject if the TASER does not work and the subject becomes out of control.

The COP determined that the tactics of Officers A, C, D, and E were seriously deficient and required AD for Unauthorized Tactics. The COP directed the CO's of the involved areas to schedule these officers for training at TD. The COP determined that Officers K, N, M, and N's tactics were appropriate, requiring no further action.

The COP found Officers C, D, E, K, L, M, and N's drawing in policy, requiring no action.

Based upon the above, the COP found the less-lethal use of force by Officers A, D, and E to be out of policy, warranting AD for Unauthorized Force. The COP directed the CO for the involved area, to schedule Officers A, D, and E for training at TD. The COP found Officer K's less-lethal use of force to be in policy, no action.

The Commission adopted the recommendations of the COP.

As a result of the AD findings, a related complaint investigation, CF No. 06-5379, was initiated. The investigation resulted in four allegations against Officers A, C, D, and E for Unauthorized Tactics. Additionally, three allegations against Officer A, D, and E for Unauthorized Force were Sustained. Officers A, D, and E received an Official Reprimand, and Officer C received an Admonishment. Officer C received a lesser penalty because he/she was not involved in the use of Unauthorized Force.

Based on our review of the complaint histories of the involved officers, the OIG believes that the penalties were appropriate for Officers C, D, and E. We believe, however, as a supervisory employee, Officer A's lack of leadership and direction in failing to develop an appropriate tactical plan for a barricaded subject, not establishing containment of the residence, delayed notification to the division, and his/her decision to remain outside the residence during the confrontation and detainment of the subject merited a higher penalty. Additionally, Officer A gave the order to use the beanbag projectile shotgun and TASER without a designated CSCT in place. Furthermore, Officer A issued the order, in the absence of exigent circumstances, to use the beanbag shotgun while specially training personnel were already deployed and allowed the other occupants of the residence to remain inside for some time during the standoff with Subject 1. We believe these decisions, which also demonstrated a lack of supervisory judgement, further compelled a higher penalty for Officer A.

ND No. 05-114

Officers A and B, who were booking a prisoner, had placed their service pistols in the trunk of their assigned vehicle for safekeeping during the prisoner booking process. When Officer A returned to the vehicle, Officer A went to the trunk to retrieve Officer A's service pistol. As Officer A went to retrieve the pistol, Officer A noted that Officer B's service pistol was placed somewhat on top of Officer A's pistol. When Officer A moved Officer B's pistol, it discharged a round. Officer A indicated that Officer A unfamiliar with Officer B's pistol and he/she was not certain whether, when Officer A moved Officer B's pistol, Officer A had his/her finger on the trigger of that pistol. The round exited the trunk, entered and exited the right rear tire, and a portion of the round came to rest in the parking lot.

The COP noted that a negligent discharge was a serious incident and cannot be mitigated and thus, found that Officer A's use of force to be negligent, warranting AD. Further, the COP

directed Officer A to additional firearms training at TD. The COP also directed the CO to provide training to Officer A regarding wearing a ballistic vest while working uniformed patrol.

The Commission adopted the recommendations of the COP.

As a result of the AD finding, a related complaint investigation, CF No. 06-4574, was initiated. The investigation resulted in one allegation against Officer A for accidental negligent discharge of a firearm. The allegation was Sustained, and Officer A received a three-day suspension. The OIG believes this penalty was appropriate because Officer A had a prior Sustained accidental discharge allegation as a probationary officer for which he/she received a two-day suspension.

LERI No. 05-066

Officers A and B were working in plainclothes capacity, attempting to locate a homicide suspect. Officers A and B were parked in their unmarked van, observing the location. Officers A and B noticed a group of males they believed to be gang members. Officers A and B observed Subject 1 holding up gang signs at another male and then saw Subject 1 run into an apartment building. Subject 1 then returned, continued to throw gang signs, and was holding his front pocket area. Subject 1 then ran into the lot where Officers A and B were parked, holding his right front pants pocket as he ran across the street. Subject 1 began speaking with other males in the parking lot. The group then walked over towards the surveillance vehicle, and Officer B observed Subject 1 continuing to hold his waistband area.

Officers A and B heard a portion of the group's conversation, which consisted of Subject 1 stating that he had the "ammo." This, and Subject 1's prior actions, led Officers A and B to believe that Subject 1 was armed.

The group then walked back towards the apartments where the officers had first observed them. Subject 1 ran inside an apartment once again, then exited, and got into a vehicle. The vehicle left the scene, and the Officers lost sight of it. Approximately five minutes later, the vehicle re-appeared. Officer B broadcast that they had a possible man with a gun inside a vehicle and requested a marked unit to respond.

Officers C and D responded to the request and stopped the vehicle. Officers C and D drew their service pistols, exited the patrol car, and ordered four occupants to kneel. Three complied with the Officers' orders and got on their knees. Subject 1 stated that he had a cramp in his leg and was unable to get on his knees. Officer C stated that at this time, Subject 1's hands were on his head, he was looking back at Officer C, and he was making "forward movements."

Officer C began to approach Subject 1 because Officer C believed that Subject 1 looked like he was going to run. Officer C holstered his/her weapon and at the same time grabbed a hold of Subject 1. Officer C believed that the butt of his/her radio made contact with the back left side of Subject 1's head, possibly while Subject 1 was already on his way down to the ground. Subject 1 stated that he was hit on the head by the Officer's gun and that his head hurt. Officer C then handcuffed and searched all three subjects. The fourth subject was patted down and searched but not handcuffed because there were no more handcuffs remaining.

Officer C then searched the vehicle for weapons but did not find one. All four subjects were

identified and checked for warrants with negative results. All four subjects were then released.

The COP noted when the vehicle returned, Officer A broadcast that he/she had a possible man with a gun in a vehicle and requested a street patrol unit to respond. The COP would have preferred that the broadcast would have included a definitive description of the vehicle, number of suspects, their descriptions, and who they perceived to be armed with a gun.

The COP also noted that the investigation determined that Officers C and D did not know that Officers A and B were working on that particular day and what type of vehicle they were in. The COP would have preferred that Officers A and B would have advised the watch commander of their mission and made patrol personnel aware that they were deployed.

The COP noted that Officers C and D responded to the area and were directed via radio by Officers A and B to the vehicle. Officer C observed four males who exited the vehicle. Officer D positioned the police vehicle to conduct a high-risk stop. The COP would have preferred that Officers C and D slowed their response and coordinated a tactical plan that would have included further direction from Officers A and B and the response of additional uniformed personnel to detain the four individuals.

The COP noted that Officer C stated that he/she attempted to advise CD of their location and requested a back-up and air unit to respond prior to exiting the vehicle; however, the request was never received by CD. The COP further noted that the investigation revealed that at the time Officer C was making the requests through CD, there was another incident area involving a unit following a possible armed suspect in a vehicle. The investigation also revealed that Officers C and D did not clear themselves from an earlier incident and did not update their status.

The COP also noted that Officers C and D exited the police vehicle and drew their service pistols to conduct a high-risk stop. Officers C and D ordered the individuals to a prone position on the sidewalk. The COP further noted that Officer B stated that he/she heard both Officers C and D giving commands to the individuals and that multiple officers giving commands creates confusion. Officer C attempted to broadcast and give commands to the suspects. The COP would have preferred that Officers C and D had not deviated from their contact and cover responsibilities, which diminished their abilities to control the four individuals.

The COP noted that Officer C decided he/she did not like the confined space and ordered the individuals to their knees closer to the wall. The COP would have preferred that Officer C would have left the individuals in a prone position. Repositioning the individuals to their knees gave them an opportunity to resist the Officers' commands.

The COP noted that Subject 1 stood up and stated he had a cramp in his leg and could not get on his knees. Officer C approached to handcuff him and motioned with his/her left hand, which held the ASTRO radio, for Subject 1 to get down. As he/she approached, Officer C holstered his/her service pistol and continued to motion with his/her left hand. As he/she came within arm's length of Subject 1, he/she accidentally struck Subject 1 on the back left side of the head with his/her ASTRO radio. Officer C grabbed Subject 1 by the hand with his/her right hand, put his/her ASTRO radio away and handcuffed Subject 1. The COP would have preferred that

Officer C did not approach Subject 1 with his/her service pistol in his/her right hand and his/her ASTRO radio in his/her left hand, which limited his/her tactical options.

Finally, the COP noted that Officers A and B cleared the location prior to the uniformed officers completing their investigation. The COP would have preferred that they would have remained present throughout the investigation and not cleared until it was tactically advisable.

Based upon the above, the COP determined that Officers C and D's tactics were seriously deficient and required AD. The COP further determined that Officers A and B would benefit from additional tactical training.

The Commission adopted the recommendations of the COP.

In the related complaint investigation, CF No. 06-3541, two allegations were Sustained for Officer C for Unauthorized Force and Unauthorized Tactics during CUOF. Additionally, there was one Sustained allegation for Officer D for Unauthorized Tactics. Officer C received a one-day suspension, and Officer D received an Admonishment.

The OIG believes Officer C should have received a higher penalty because he/she received AD for both Unauthorized Force and Tactics. We also believe Officer D should have received a higher penalty in this case because he/she had a prior Sustained complaint for Unauthorized Force and Tactics, which resulted in an Official Reprimand.

ICD No. 05-071

CD received a 911 call indicating that two males were fighting in an apartment building and that one of the males was attempting to break in the front door of an apartment. As they arrived at the scene, Officers A and B saw Subject 1 crawling out of a doorway, into the driveway of the apartment building. According to Officer A, Subject 1 was screaming and making unintelligible noises. According to Officer B, Subject 1 was speaking Spanish, asking for the police. Subject 1's pants were pulled down around his knees. Also in the driveway, close to Subject 1, were two males and a female. Officer B asked them what was wrong with Subject 1. The three individuals walked away from the Officers.

According to Officer B, an unidentified neighbor informed him/her that he/she should detain the individuals walking away. Believing they were possibly involved in the reported incident, Officer B followed in order to detain them, leaving Officer A alone with Subject 1.

Officer A looked away from Subject 1 to see where his/her partner was going. Officer A then looked back toward Subject 1 and saw that Subject 1 had stood up and was walking toward Officer A, staggering from side to side. Officer A gave verbal commands to Subject 1 to "Stop." Subject 1 did not respond to Officer A. Officer A attempted to take hold of Subject 1's right arm. Subject 1 then tripped over a planter and fell to the ground. According to Officer A, Subject 1 did not fall very hard.

Officer A told Subject 1 to give Officer A his hand. Subject 1 screamed unintelligibly and did not comply with Officer A. Officer A then took hold of Subject 1's left hand, placed a handcuff on Subject 1's left wrist and instructed Subject 1 to give Officer A his right hand. Subject 1 did

not comply. Officers C and D responded to the scene and observed Officer A attempting to handcuff Subject 1. Both Officers observed that Subject 1 was resisting Officer A.

Officers C and D approached Officer A to assist. Officer C held Subject 1's right arm and Officer D held Subject 1's left arm. Officer A then applied a handcuff to Subject 1's right wrist. After the handcuffs were applied, Subject 1 continued to move his legs. Officer C instructed Officer A to apply a Hobble Restraint Device (HRD) to Subject 1's legs. While Officer A held Subject 1's legs, Officer C took hold of Subject 1's ankles and applied the HRD.

According to Officer C, once the HRD was applied, four or five attempts were made to sit Subject 1 up. However, according to Officer C, Subject 1 was "thrashing about" and would not sit up, and the officers placed him on his side.

Meanwhile, Officers E and F responded to the scene. Officer E saw Officer B conducting a pat-down search of a male on a landing in front of an apartment building. Officer E approached Officer B and asked him where Officer A was. Officer B pointed across the street.

Officer E saw that Subject 1's eyes were rolled back, and that Subject 1 was not moving. Officer E instructed Officer A to request an RA. Subject 1 was later pronounced dead. A subsequent autopsy determined that Subject 1 had consumed amphetamine, methamphetamine and cocaine. The Coroner deemed the manner of Subject 1's death to be accidental.

The COP noted that Officers A and B parked directly across the street from the radio call location, which placed the Officers at a tactical disadvantage. The COP would have preferred that the Officers had parked a safe distance from the call location and had approached on foot.

The COP noted that, prior to controlling Subject 1, Officer B crossed the street to detain two possible suspects, leaving Officer A alone with Subject 1. The separation distance was approximately 60 feet. Subsequently, Officer A became involved in a use of force with Subject 1 by himself. The COP also noted that Officer B was unaware of the struggle that initially occurred between Officer A and Subject 1 and was critical of Officer B's decision to separate from Officer A. The COP noted that Officer B was not in a position to provide immediate assistance due to the distance and focusing his/her attention on the additional suspects.

The COP also noted that Officers E and F were at the location for approximately 10 minutes prior to advising CD of their status and would have preferred that the Officers had immediately notified CD of their arrival.

The COP was critical of the Officers' decision not to make additional attempts to place Subject 1 into an upright seated position. The COP was also critical that the HRD was not removed once it was discovered that Subject 1 was experiencing distress, noting that the time between the officers recognition of Subject 1's medical distress and the arrival of the RA was approximately four minutes and twenty seconds. The COP found that the Officers failed to follow Department policy in regard to proper procedures following the application of handcuffs and a HRD.

The COP determined that Officer A, B, C, D and E's tactics were severely deficient, requiring AD. Additionally, the COP directed the CO to schedule them for the appropriate training at TD.

The COP determined that Officer F would benefit from additional training and directed the CO to provide and document the appropriate training for the officer.

The Commission adopted the recommendations of the COP.

As a result of the AD finding, CF No. 06-3786, was initiated. The investigation resulted in five allegations against Officers A, B, C, D, and E for involvement in an In-Custody Death incident. These allegations were Sustained, and Officer B received a two-day suspension. Officers A, C, D and E received Official Reprimands. The OIG believes that the penalty for Officer B was appropriate because he/she was a training officer and should have been held to a higher degree of accountability. Moreover, Officer B should not have split up from his/her probationary partner which put him/her at a tactical disadvantage. The penalties for Officers A, C, D and E were appropriate because they had no prior Sustained complaints for similar allegations and they were also to receive directed training for application of handcuffs and the HRD.

VI. Conclusion

Overall, the OIG noted relatively few investigative concerns in the ethnic remark and gender bias cases we reviewed. Indeed, it appears that the Department has taken account of our previous recommendations in regards to these types of cases. However, most of the investigations we reviewed were fairly short in length, and employed what could be considered a short form template, including short paraphrases of essential interviews. Given the severity of allegations made in these types of cases, we would recommend that the Department encourage the full exploration of all of the issues raised by these types of complaints. For example, in one case in which we identified significant investigative issues, a lack of thorough paraphrasing of the interviews resulted in a hampered investigation. Ultimately, we believe that this is a relatively minor concern in light of the overall progress made by the Department since our last Report on these topics.

We also commend the Department for their willingness to explore the feasibility of preparing reply letters to non-English speaking complainants in their native languages.