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# COLLABORATIVE REFORM MODEL

## A Review of Officer-Involved Shootings in the Las Vegas Metropolitan Police Department

James K. Stewart ■ George Fachner  
Denise Rodrigues King ■ Steve Rickman



**COPS**  
Community Oriented Policing Services  
U.S. Department of Justice

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ANALYSIS & SOLUTIONS

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## Letter from the Director

Dear Colleagues,

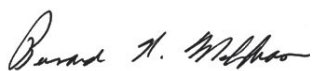
The COPS Office developed the Critical Response Technical Assistance Program in 2011 to provide technical assistance to agencies on significant law enforcement-related issues. Using subject-matter experts, interviews, direct observation, and conducting research and analysis, the COPS Office assists law enforcement agencies with enhancing and improving their policies and procedures, their systems, and their culture. If appropriate, the COPS Office can issue a series of recommendations, and be instrumental in assisting agencies with the implementation of those recommendations or finding the right resources to do so.

For this report, one of the most important issues facing law enforcement is public perception of the legitimate use of force. Far too often, the public perception of police use of force is entirely different from those who are in law enforcement. The public's perception is heavily influenced by a variety of factors (including media coverage), and exacerbated by the increasing power and speed of social media technology. Incidents of use of force can create a false narrative for the public concerning the appropriateness of police actions—a narrative that is not statistically representative or supported by data.

It was through the Critical Response Technical Assistance initiative that the COPS Office began working with the Las Vegas Metropolitan Police Department (LVMPD), to provide an in-depth analysis of five years of officer-involved shootings. This work was in part a response to a five-part series published in the *Las Vegas Review Journal* in December 2011, titled: "Deadly Force: When Las Vegas Police Shoot, and Kill." After a series of conversations between the COPS Office and the LVMPD, we worked with our grantee—the CNA Corporation—and collaborated to help LVMPD achieve the following goals: (1) reduce the number of officer-involved shootings; (2) reduce the number of persons killed; (3) change the culture of LVMPD as it relates to deadly force; and (4) enhance officer safety.

This report, *Collaborative Reform Model: A Review of Officer-Involved Shootings in the Las Vegas Metropolitan Police Department*, is a result of that comprehensive work. It provides a detailed analysis of the subject matter and includes findings, recommendations, and implementation guidance. While the COPS Office recognizes that these goals are ambitious, we believe this report will prove a valuable resource—not just for LVMPD, but for the field as a whole—to help impact the critical relationship between police and the communities they serve. We hope that this analysis and its recommendations will help your agency and community work together to successfully navigate these issues, as well as enhance understanding and communication.

Sincerely,



Bernard K. Melekian, Director  
Office of Community Oriented Policing Services



## **Acknowledgments**

The authors of this report are: James K. Stewart, Senior Fellow, Institute for Public Safety; George Fachner, Research Analyst; Denise Rodriguez King, Associate Research Analyst; and Steve Rickman, Director, Homeland Security. They wish to thank Joshua Ederheimer, Tawana Waugh, and Katherine McQuay, from the COPS Office, without whom this report would not have been possible.

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## Executive Summary

The use of deadly force against a citizen is the most serious act a police officer can take. It demands careful, impartial review and the highest professional standards of accountability. In November 2011, the *Las Vegas Review Journal* (RJ) published a five-part investigative series titled “Deadly Force: When Las Vegas Police Shoot, and Kill.” The RJ series, using data provided by the Las Vegas Metropolitan Police Department (LVMPD), reviewed officer-involved shootings (OIS) over the past 20 years. The RJ reported that although a number of these shootings were highly controversial and could have been avoided, LVMPD’s internal accountability systems and the Clark County Coroner’s Inquests had ruled that they were justified and held officers minimally accountable. As expected, the RJ investigative series raised concern for the community about LVMPD’s lack of police accountability both to the department’s review bodies and to community stakeholders.

In January 2012, in response to the RJ’s investigative series, the director of the Office of Community Oriented Policing Services (COPS Office) of the U.S. Department of Justice called LVMPD’s Sheriff Gillespie. The director offered the assistance of the COPS Office through its Critical Response Technical Assistance grant to reduce OISs. Within a week of this phone call, Sheriff Gillespie sent members of his executive command to Washington, D.C., to meet with the COPS Office. They discussed the reforms that LVMPD was already undertaking to address the issue and the areas in which technical assistance would be beneficial.

Simultaneously, the American Civil Liberties Union of Nevada (ACLUNV) filed a petition with the U.S. Department of Justice Civil Rights Division on behalf of the Las Vegas chapter of the National Association for the Advancement of Colored People (NAACP). The petition requested that the Civil Rights Division commence an investigation and pursue civil remedies to reform the LVMPD, claiming that the LVMPD “engaged in a pattern or practice of conduct by law enforcement officers...that deprives persons of rights, privileges or immunities secured or protected by the Constitution or laws of the United States.”<sup>1</sup>

In late January 2012, the COPS Office asked CNA to examine the LVMPD’s policies and practices as they relate to the use of force and OISs. The goals of this review—and, subsequently those of the reforms identified by both LVMPD and CNA—were as follows:

- Reduce the number of shootings
- Reduce the number of persons killed as a result of OISs
- Transform LVMPD’s organization and culture as it relates to deadly force
- Enhance officer safety

The focus of the COPS Office and CNA review centered on LVMPD deadly force issue areas involving: 1) policy and procedures; 2) training and tactics; 3) investigation and documentation; and 4) review.

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1. American Civil Liberties Union of Nevada, *Petition for an Investigation into the Las Vegas Metropolitan Police Department by U.S. Department of Justice Pursuant to 42 USC [4]*. (Las Vegas, Nevada: ACLU, 2012).

CNA implemented a multifaceted approach to the review of LVMPD's policies and practices by:

- Interviewing nearly 100 officers and community stakeholders
- Directly observing LVMPD's internal and policing (external) operations
- Conducting a detailed study of volumes of internal documents
- Conducting an analysis of LVMPD data on OISs
- Reviewing relevant national standards and practices of other similar jurisdictions
- Delivering direct technical assistance and establishing a collaborative partnership with LVMPD throughout this engagement

After six months of conducting its review and collaboratively working with LVMPD, CNA and the COPS Office documented 40 LVMPD reforms regarding use of force policies and other areas related to OISs. Additionally, CNA has made 35 new findings and 40 new recommendations. Major findings and recommendations include the following:

**Officer-initiated stops are more likely to result in a shooting of an unarmed suspect than any other type of contact.**

**Recommendation:** LVMPD should conduct uniform training on the legal parameters of officer-initiated contacts (e.g., consensual stops, investigative detention) throughout the department, starting with proactive entities such as the Gang Crimes Bureau. LVMPD has created training videos on constitutional policing issues. LVMPD should continue to incorporate additional training on this topic into scenario-based and role-playing training modules.

**LVMPD's new Use of Force Policy is comprehensive; however, the format is cumbersome and not structured in a clear and concise manner that allows officers to quickly apply guidance in the field.**

**Recommendation:** LVMPD should separate its Use of Force Policy into several smaller, specific policies. This should include a core policy that serves as the foundation for the other related policies. Examples of stand-alone policies include rifles, shotguns, and other firearms; Electronic Control Devices (ECD); less-lethal shotguns; batons; Oleoresin Capsicum (OC) spray (also known as Pepper Spray); and other less-lethal weapons.

**LVMPD's de-escalation training is not required for officers and does not include an evaluation component.**

**Recommendation:** LVMPD should establish an annual requirement for officers at the rank of sergeant and below to undergo a minimum number of hours of de-escalation training and formalize assessments of de-escalation tactics in Advanced Officer Skills Training (AOST) and Reality-Based Training (RBT). LVMPD should also devote one quarter of its defensive tactics training to de-escalation.

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**LVMPD needs to better manage multiple-officer situations. Tactical errors and fatalities are more prevalent when multiple officers are on the scene.**

**Recommendation:** LVMPD should ensure that supervisors and officers are prepared to handle multiple officer situations in the context of deadly force. It should use reality-based incident command scenarios to train supervisors and officers on the management and direction of multiple officers during a critical incident.

**LVMPD developed a Force Investigation Team (FIT) model in late 2010. In April 2012, citing manpower issues, the Robbery and Homicide Division stopped the FIT model of one squad handling all officer-involved uses of deadly force. They returned to a process of all Homicide squads handling the investigations on a rotating basis.**

**Recommendation:** LVMPD should re-establish a specialized group of investigators designated to conduct comprehensive deadly force investigations, in conjunction with the District Attorney's Office, that are legal in nature.

In addition to the recommendations that CNA made, LVMPD has simultaneously made a number of organizational reforms since the start of this initiative. Reforms initiated by LVMPD include forming the Office of Internal Oversight (OIO); updating the department's Use of Force Policy; expanding the scope of the Use of Force Review Board by establishing new findings; and releasing the OIO summary reports on OISs to the public. Not only has LVMPD consulted with CNA in making these reforms, they have also taken the recommendations made by the ACLU into consideration. As an example, it has added a "reverence for life" statement in the department's recently updated Use of Force Policy.

In order to help the LVMPD implement the reforms identified in this report, CNA has developed implementation steps for each recommendation made. This implementation plan identifies the next steps required to carry out these reforms. Upon release of this report, LVMPD and CNA will review the implementation plan and determine the necessary steps and timeframe required to carry out the reforms. After six months, the COPS Office will review the status of each reform listed in the plan.





## Chapter 1: Introduction

Police are legally authorized to use deadly force under narrowly defined circumstances. Taking the life of a citizen is the most serious action that an official can take. This action needs to be carefully reviewed to ensure that the decision complied with the Constitution, case law, professional standards, and community expectations. The requirement for a transparent and impartial investigation of the totality of circumstances of such matters is fundamental to our nation's founding principles and to police officers' obligation to protect and serve their community.

### Chronology of events

In November 2011, the *Las Vegas Review Journal* (RJ) published a five-part investigative series titled "Deadly Force: When Las Vegas Police Shoot, and Kill." The RJ series reviewed officer-involved shootings (OIS) in Clark County over the past 20 years.<sup>2</sup> The newspaper reported that, although a number of these shootings were highly controversial and avoidable, LVMPD's internal accountability systems and the Clark County Coroner's Inquest ruled them to be justified. These OIS cases often involved shootings in which the subject was unarmed or options other than deadly force could have been used. The RJ investigative series raised concerns about LVMPD's lack of police accountability both to its own review bodies and to community stakeholders.

Segments of the Las Vegas community were outraged by the apparent lack of accountability in LVMPD. LVMPD's lack of executive, command, and supervisory action to control the use of deadly force by LVMPD officers and the failure of internal and external review bodies to hold officers accountable continued to be a source of extreme concern among the community.

In January 2012, the American Civil Liberties Union of Nevada (ACLUNV) filed a petition with the U.S. Department of Justice Civil Rights Division on behalf of the Las Vegas chapter of the National Association for the Advancement of Colored People (NAACP). The petition requested the Civil Rights Division to commence an investigation and pursue civil remedies to reform the LVMPD because of alleged patterns and practices in OISs, among other department actions, that "deprive persons of rights... secured under the Constitution of the United States."<sup>3</sup>

Although it is not the purpose of this report to reinvestigate any OIS cases, one particularly troubling OIS incident serves as an example of the concerns of the RJ, NAACP, ACLU, and broader Las Vegas community. In June 2010, an LVMPD officer shot and killed Trevon Cole, a small-time marijuana dealer with no record of violence, while serving a search warrant of Cole's apartment on East Bonanza Road. Cole was unarmed and was kneeling in the bathroom (presumably to dispose of contraband) when he was shot with a department-issued .223 rifle. This was the third OIS and second fatality for the officer involved. The District Attorney (DA) did not file criminal charges. The case went to the Clark County Coroner's Inquest, where the jury unanimously ruled that this use of deadly force was justifiable. The case was then presented internally, in the LVMPD Use of Force Review Board, and members unanimously voted that it was justified.

2. See "Deadly Force: When Las Vegas Police Shoot, and Kill," *Las Vegas Review Journal*, [www.RJ.com/news/deadly-force](http://www.RJ.com/news/deadly-force).

3. American Civil Liberties Union of Nevada, *Petition for an Investigation into the Las Vegas Metropolitan Police Department by U.S. Department of Justice Pursuant to 42 USC [4]*. (Las Vegas, Nevada: ACLU, 2012).

The Office of Community Oriented Policing Services (COPS Office) of the U.S. Department of Justice was monitoring the situation in Las Vegas, as a result of the RJ series, and contacted LVMPD shortly before the ACLU/NAACP petition was filed in January. To address the community's concern about LVMPD's use of deadly force, the COPS Office offered LVMPD assistance through its Critical Response Technical Assistance program. Within a week of this phone call, Sheriff Gillespie sent members of his executive command to Washington, D.C., to formally meet with COPS Office personnel and technical assistance provider, CNA. They discussed the reforms that LVMPD was already undertaking to address the issue and the areas in which technical assistance would be beneficial.

### ***Technical assistance goals***

As a result of this meeting, LVMPD, the COPS Office, and CNA reached an agreement for CNA to perform an independent assessment and provide collaborative technical assistance to LVMPD with respect to its OISs. The assessment would entail a review of policies, training, and the system of accountability for LVMPD related to OISs. CNA began working with LVMPD to develop and implement reforms while completing this assessment. Progress made in this collaboration is also captured in this report.

The goals of the assessment and technical assistance were to provide LVMPD with recommendations that would help the department do the following:

- Reduce the number of OISs
- Reduce the number of persons killed as a result of OISs
- Transform LVMPD's organization and culture as it relates to deadly force
- Enhance officer safety

The following section briefly introduces the issue areas and discusses how they relate to these goals.

### **Issue areas**

The COPS Office and CNA's assessment of LVMPD operations with respect to OISs focuses on policy, training, and accountability systems. Those are the primary mechanisms through which the department establishes and reinforces its standards of conduct and organizational culture. They form a cycle of continuous improvement that will ultimately help the department reduce the number of OISs and the number of persons killed as a result.

The focus of the COPS Office/CNA review centered on LVMPD deadly force issue areas involving: 1) policy and procedures; 2) training and tactics; 3) investigation and documentation; and 4) incident review.

Specifically, CNA examined the department's Use of Force Policy, which defines the standard of conduct for all sworn personnel. We identified six types of training that relate to OISs and assessed these programs, providing recommendations for improvement. We reviewed the relevant internal and external accountability systems. Internally, accountability consists of LVMPD's Force Investigation Team, Critical Incident Review Team, and Use of Force Review Board. External accountability consists of the District Attorney's Office and the Coroner's Inquest. In addition to these formal mechanisms of accountability and control, we discuss overarching community concerns and LVMPD's responsiveness to those concerns.

### ***Use of force policy and procedures***

A police department's use of force policy is an important component of preparing officers—it provides the officer, the community, and the accountability bodies with the basis for understanding proper procedure and tactics. The policy will ultimately dictate the way in which officers use force and, therefore, the prevalence of force incidents, including OISs.<sup>4,5</sup> Use of force policy not only shapes officers' actions, it can also potentially help shape their understanding of deadly force and, therefore, the organization's culture as it relates to this issue.

LVMPD recently made substantial revisions to its General Order on use of force to account for the recent finding of the Ninth Circuit Court, the input of internal stakeholders in the department and external stakeholders in the community, and a review of policies from similar sized agencies to determine industry standards.<sup>6</sup> The order not only describes the parameters for using force but also provides a use of force model, standard definitions of terms, and language that adds context and justification for the policy.

The order comprises 11 parts, each covering a topic pertaining to the use of force: policy; definitions; use of force to effect a detention, an arrest, or to conduct a search; a determination of objectively reasonable force; duty to intervene; levels of resistance; levels of control; use of force model; de-escalation; authorized force tools, techniques, and equipment; and reportable force incidents.

### ***Use of force training and tactics***

Policy determines the appropriate procedure tactics and their parameters, and training reinforces those concepts, giving officers the technical skills needed to accomplish their goals of public safety and officer safety. Particular techniques and tactics, such as de-escalation, have been known to reduce the need to use force.<sup>7</sup> Police leaders recently acknowledged that improper uses of force are often the result of officers not using the tactics they were trained to use.<sup>8</sup> It stands to reason that an efficient and effective training program is one that reduces the need for officers to use force, including deadly force.

4. J.J. Fyfe, "Administrative Interventions on Police Shooting Discretion: An Empirical Examination," *Journal of Criminal Justice* 7, no. 4 (1979): 309–324.

5. M.D. White, "Assessing the Impact of Administrative Policy on Use of Deadly Force by On- and Off-Duty Police," *Evaluation Review* 24 (2000): 295–318.

6. LVMPD, "Use of Force General Order," (2012).

7. J.J. Fyfe, "Training to Reduce Police-Civilian Violence," in *And Justice for All: Understanding and Controlling Police Abuse of Force*, ed. W. Geller and H. Toch (Washington, D.C.: Police Executive Research Forum, 1995), 163–75.

8. Police Executive Research Forum, *An Integrated Approach to De-Escalation and Minimizing Use of Force* (Washington, D.C.: Police Executive Research Forum 2011).

We examined six training modules that can impact the prevalence and nature of OISs: defensive tactics training; crisis intervention team (CIT) training; electronic control device (ECD) training; advanced officer skills training (AOST); reality-based training (RBT); and Use of Force Policy training. Each training component is described below:

- Defensive tactics training consists of hand-to-hand combat skills and is conducted on a quarterly basis for all officers at the rank of sergeant and below.<sup>9</sup>
- CIT training is specialized training for handling mentally ill suspects or those showing signs of excited delirium.
- ECD training entails the parameters of using a department-issued device and tactical exercises aimed at improving drawing, targeting, and decision making.
- AOST is an annual requirement for officers at the rank of sergeant and below, consisting of reality-based decision-making scenarios with both simulated live action and a computer simulation using interactive tools.
- RBT is a newly developed supplemental training program that is to be conducted twice a year. It is both classroom-based and Simunitions®-based (simulated weapons and/or ammunition), focusing on use of force scenarios.
- Revised Use of Force Policy training began in May 2012. LVMPD's goal of this training is to educate officers on the new elements of the policy.

### ***Use of force investigation and documentation (internal accountability)***

LVMPD has three elements in its internal accountability system: LVMPD's Force Investigation Team (FIT); Critical Incident Review Team (CIRT); and Use of Force Review Board (UoFRB). LVMPD's FIT is part of the Homicide and Robbery Division and handles the criminal investigations of OISs. CIRT is an administrative review process that focuses on policy, training, and tactical issues of an OIS. The UoFRB serves as an outlet for CIRT investigative findings. It is a voting board of citizens and sworn officers who make rulings on OISs. Taken as a whole, this internal accountability system is a lynchpin for organizational learning as it relates to use of deadly force. With each component functioning efficiently and effectively, LVMPD can leverage what is learned to improve policy, training, and tactics in a way that may reduce the number of avoidable deadly force incidents and enhance officer safety. It is noteworthy that the system is often in flux, as are its components. Roles and responsibilities have been refined and have evolved over time.

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9. LVMPD, "5/108.16, Defensive Tactics," *LVMPD Policy Manual* (no date).

## ***Use of force incident review (external accountability)***

The external accountability system consists of the DA's review of an incident and the Coroner's Inquest. Traditionally, the Clark County DA's Office would review fatal OIS cases but remain silent regarding its findings in terms of criminality. In practice, this silence implied that the OIS was not criminal, in which case it would proceed to the Coroner's Inquest. The Coroner's Inquest has been Clark County's vehicle for publicly disclosing the facts of an OIS. Like LVMPD's internal review process, the roles and responsibilities of the DA and the Coroner's Inquest have changed over time, but recent reforms have had systemic impacts. We describe these processes, their recent reforms, and their impact later in this report.

## **Organization of this report**

The next section of this report (chapter 2) describes the methodology we used to conduct our assessment. Chapter 3 details the organizational reforms that LVMPD has implemented to date, on its own initiative and with the assistance of the COPS Office and CNA. Chapter 4 presents a five-year detailed analysis of OISs in LVMPD. Chapters 5 through 9 detail our assessment of the following issue areas: use of force policy and procedures, use of force training and tactics, use of force investigation and documentation, use of force incident review, and community perspectives and outreach.

For each issue area, we provide an overview before presenting our findings and recommendations. At the request of the COPS Office and LVMPD, we have included some implementation steps for each recommendation. These are not meant to be exhaustive or definitive. We offer these only as starting points for LVMPD to use in implementing our recommended reforms. Chapter 10 concludes the report with an overview of the work that has been conducted to date and what the future holds for LVMPD concerning use of force.



## Chapter 2: Methodology

CNA's approach was multifaceted, consisting of interviews with 95 key stakeholders; direct observation of LVMPD's internal and external policing operations; detailed study of volumes of internal documents; analysis of data on OISs; and the provision of direct technical assistance during this engagement. Over the course of six months, these efforts gave the research team an in-depth understanding of LVMPD, its operations, and its culture with respect to OISs. We organize our approach into three tasks: data collection, analysis, and technical assistance. Each is described in detail in this chapter.

### Data collection

We collected data from five primary sources:

- LVMPD reports on OIS incidents
- LVMPD database on training requirements
- Stakeholder interviews
- Direct observation of operations and related activities
- LVMPD documents, policies, and general orders

### *OIS incident data*

We compiled various data sources on OISs and the LVMPD in order to develop statistical profiles and inform our findings and recommendations throughout this report. Specifically, we used a database on OISs compiled by the *Las Vegas Review Journal* (RJ) and internal LVMPD OIS incident reports. These data were used in descriptive and bivariate analyses throughout this report.

### RJ database

The RJ compiled a database of OIS incidents throughout Clark County over the past 20-plus years. For our purposes, we narrowed the scope to the past five years of OISs involving LVMPD officers only. The database includes environmental, officer, suspect, and incident-specific variables. We conducted a quality assurance check of 10 percent of the cases in the database, using the homicide files supplied to the RJ. We had the additional benefit of internal administrative files with which to cross-check the data. The database was mostly sound. In the few cases where we reclassified data, we make note of it in the body of the report.

### Internal reports

The team also used internal incident reports produced by LVMPD's Critical Incident Review Team (CIRT) and its legacy Critical Incident Review Panel (CIRP). These reports provided administrative reviews of OIS incidents, documenting tactical, training, and policy issues.

Each report was analyzed and coded to supplement the data compiled by the RJ. The reports included assessments of communications, verbal commands, officers' approach, command and control, contact and cover, and use of lethal and less-lethal force.



### ***LVMPD training data***

LVMPD's online learning system, called University of Metro Las Vegas (UMLV), provided the team with reports on training course attendance by all LVMPD officers from 2008 through 2011.

### ***Key stakeholder interviews***

We canvassed the department and the community for interview participants, relying mostly on a snowballing technique—that is, we used initial contacts to identify other relevant and interested interview participants, and so on. We identified initial points of contact through various sources, including LVMPD leadership and various media accounts. The interviews were semi-structured, allowing for digressions, depending on the interview subject's knowledge of and insights on the topic of OISs and LVMPD operations. Many interview participants in both the department and the community identified other parties who would be good informants for these topics.

Most interviews were non-attributional, in order to encourage candor. (Some interviewees, however, waived the non-attribution clause of their interview.) In this report, non-attributional interviews are simply cited as "CNA interviews," with the understanding that this process unfolded over the course of the six-month project period. If the interview was with a high-level official, we identify the interview participant.

The base interview questions gauged interviewees' perspectives on and knowledge of OIS incidents and post-incident procedures, and asked how they, due to their respective position and organization, were either an interested party or directly involved in activities related to OISs. We used these interviews to develop hypotheses and diagnostics of the department's operations with respect to OISs. In all, we interviewed 95 individuals from the department and community combined. All of them were key stakeholders with divergent perspectives on the subject of OISs in Las Vegas.

### **Department personnel**

Our strategy for interviewing members of the department was to span both the horizontal and vertical space of the ranks and divisions within, giving us various perspectives. In all, we covered a total of 53 members of LVMPD.

LVMPD interview participants spanned the organization, from patrol officers through the sheriff. They included sworn personnel at various levels of the department: patrol officers, detectives, sergeants, lieutenants, captains, deputy chiefs, assistant sheriffs, the undersheriff, and the sheriff.

Additionally, we covered various entities within the department, including the Office of Internal Oversight; Use of Force Review Board commissioned members; the patrol, traffic, gangs, narcotics, and training divisions; the Critical Incident Review, Crisis Intervention, Force Investigation, and Mobile Saturation teams; and intelligence, homicide, quality assurance, and internal affairs personnel.

We also met with and interviewed various civilian employees and stakeholders within the department, including association representatives from the Police Protective Association (PPA), the Police Managers and Supervisors Association (PMSA), the Police Protective Association for Civilian Employees (PPACE), and civilian members of the department from policy and research, the analytics sections (ANSEC), labor relations, and the legal department.

## **Community members**

Various community stakeholders participated in the interview process, including private individuals, organization representatives, and other government entities with jurisdiction in Las Vegas. In total, the team met with and interviewed 42 individuals considered to be community stakeholders.

Community members we met with and interviewed include representatives of the NAACP of Las Vegas, ACLU of Nevada, Urban League of Las Vegas, Hispanic Citizens Academy, and Sherman Gardens Council; property managers and associations; local elected officials; and various community leaders throughout the valley.

Other community stakeholders and interested parties we met with and interviewed were the chair of the citizen review board, citizen members of the UoFRB, former LVMPD officers, the district attorney, the FBI Special-Agent-in-Charge for Las Vegas, and the county coroner.

## ***Direct observation***

On many occasions we were able to directly observe some of the department's activities related to OISs. Specifically, we observed UoFRB proceedings, Use of Force Policy revision training, advanced officer skills training (AOST), reality-based training (RBT), and electronic control device (ECD) training. We also took part in "ride-alongs" with patrol and gang units.

## **Use of force review boards**

We observed all six UoFRB proceedings conducted during our six-month engagement. By doing so, we were able to qualitatively assess the board—including the presentation by the lead investigator—the group's dynamics, the dialogue (i.e., questions and answers) between board members and involved officers, the duration of the proceedings, and the particular points and issues that were emphasized. Our observations included a mix of actors and participants, including two board chairs; various gang detectives, patrol officers, and civilian members; and four lead investigators. The UoFRBs we observed accounted for both fatal and non-fatal OISs. Additionally, we observed the board as it transitioned its findings structure from a simple dichotomy of justified/unjustified to a wider array of findings.

## Training observations

Team members observed four distinct training modules: Use of Force Policy revision; AOST; RBT; and ECD training.

When the department revised its Use of Force Policy in June 2012, it implemented training on the new policy across its entire workforce. This took place over the course of approximately six weeks, as it covered 2,763 sworn and non-sworn personnel in over 70 classes held at the Keller Training Academy. We observed five of the training sessions, assessing both the content and its delivery, according to the established learning objectives for the course. Additionally, we were able to gauge the quality of the training delivery, which included measures of the trainer-trainee interaction, clarity of the presentation, any common points of contention, and the trainer's knowledge of the material. Two team members observed each training session. The five sessions we observed represented about 7 percent of the total training sessions delivered.

The analysis team also observed three tactical training modules conducted at LVMPD's training facility: ECD, AOST, and the department's newly implemented RBT training. By doing so, the team observed the entire mandatory use of force scenario training that an LVMPD officer would be required to attend over the course of a year. Although the content of the training was available on paper, direct observation gave us a more in-depth, qualitative understanding of how the training is delivered and how officers are assessed by training staff. Additionally, we were able to discuss each program with trainees and trainers at the start and end of the program.

## Ride-alongs

The analysis team participated in five "ride-alongs" with patrol and gang units, primarily in order to observe different area commands in Las Vegas and the way in which officers conduct themselves. The number of observations was far too small to be considered significant, and no conclusions can be drawn from these observations. However, these experiences added qualitative richness to our other modes of inquiry.

## *Document review*

The analysis team reviewed volumes of documents from LVMPD concerning policy development, training, and internal investigations. This enabled the team to conduct a system-wide assessment of OISs in LVMPD, including pre-incident parameters set forth by the department's policy and training manuals, the dynamics of the incidents themselves, and the outcomes of internal reviews and accountability metrics.

Specifically, we reviewed LVMPD's policy manual, use of force training materials, critical incident reports, OIS homicide reports, and use of force board memoranda. We also reviewed documents and reports from other organizations, including other police departments across the country and national associations, various studies on use of force policies and procedures, and reports by the ACLU of Nevada on LVMPD policies and practices.

## Analysis

Our analysis relied primarily on an inductive approach. In other words, through our data analysis, interviews, observations, and document review, we identified gaps and weaknesses in LVMPD operations. We sought to explain and address those gaps and weaknesses with our understanding of LVMPD's organizational structure and operations, consultation with other police departments and subject matter experts, and a review of the existing research on our topics of interest: policy, training, and police accountability.

### *OIS data analysis*

Our data analysis, presented in Chapter 4, is largely descriptive. The analysis gives context to OIS incidents and identifies significant associations among various incident characteristics, including outcomes. We explored these relationships quantitatively in univariate and bivariate analyses, integrating multiple data sources, including LVMPD internal reports, the RJ database, the U.S. Census, and the Federal Bureau of Investigation's Uniform Crime Reports.

### *Policy and practice analysis*

Our analysis of LVMPD policy and practice (i.e., training, FIT, CIRT, and UoFRB) and other functions in Clark County (i.e., the DA's Office and the Coroner's Inquest) was qualitative in nature. We identified recurring themes in our interview notes, examined operations as formally detailed in policy and through direct observations, conducted research on professional standards and common practices, and consulted with other police departments, practitioners, and researchers on ways to improve operational efficacy in LVMPD and beyond.

Specifically, our analysis addressed the following:

- What stakeholder concerns are the most prevalent?
- Are these concerns supported or clarified by other data sources?
- What is LVMPD doing to address these concerns?

We use our analysis in this report to document and support each of our observations and to provide recommendations that LVMPD or the cognizant organization can use to implement solutions.

## Technical assistance

The purpose of this initiative was not only to conduct an assessment and produce a report, but also to actively engage with the department throughout this process and help initiate reform early on—during the study. The CNA analysis team frequently consulted with and shared insights with LVMPD leadership on its operations throughout this six-month engagement. Some of these conversations led to immediate action. We document these instances throughout this report.



## Chapter 3: LVMPD Reforms

Five years ago, the accountability mechanisms that LVMPD had in place to impartially and thoroughly review OISs were extremely limited. For example, the Use of Force Review Board focused its review on the moment an officer discharged his/her firearm. This narrow scope produced judgments that were almost always justified. In addition, issues with transparency, the DA's Office, and the Coroner's Inquest process documented in other sections of this report contributed to community concern about OISs.

In 2010, LVMPD experienced its highest number of OISs (25 total). Incidents such as the Trevon Cole and Eric Scott cases were particularly controversial; they received high levels of attention from the media and caused an uproar within the community. As a result, LVMPD has been transforming its organization with the goal of reducing the number of OISs. Members of LVMPD executive command staff visited police departments across the country and examined promising practices from research organizations and professional associations in order to find best practices in investigating OISs and police accountability.

Using what they learned from other police departments, LVMPD revamped its criminal and administrative investigations of OISs by forming Force Investigative Teams (FIT) and the Critical Incident Review Team (CIRT). LVMPD also made additional changes to its policies and training.

After the release of the *Las Vegas Review Journal's* (RJ) five-part investigative series and the subsequent complaint filed by the ACLU, the COPS Office offered LVMPD technical assistance to continue its efforts to accelerate reform. CNA delivered that assistance, providing an objective, third-party perspective on the reforms. LVMPD also took the recommendations from community stakeholders, such as the ACLU, into consideration. With assistance from CNA, LVMPD initiated additional reforms, which included updating the department's Use of Force Policy, implementing new determinations for the Use of Force Review Board, releasing FIT and Office of Internal Oversight (OIO) summary reports to the public, and training the entire department on the new Use of Force Policy.

Vital to all of these reforms was the need to create organizational change. Without change at the organizational level, any new reforms would be viewed as "programs," which may or may not last. Instead, these reforms had to be institutionalized at an organizational level for lasting reform to take place and ultimately transform the culture of the agency.

### Organizational reforms

LVMPD implemented several new organizational positions and changes to ensure systemic and long-lasting change. To begin with, the department designated a single command official responsible for managing use of force reforms. This individual will lead LVMPD's efforts to reform its Use of Force processes. This command official will be the primary liaison to the community, the U. S. Department of Justice, and other stakeholders, and report directly to the sheriff. Additionally, the command official's position is housed in the newly established OIO, which was the office established to serve as the liaison to CNA and the COPS Office and to implement use of force reforms. The OIO's mission is to significantly reduce deadly force incidents.

LVMPD established FIT in late 2010, with the purpose of conducting all deadly force investigations from a legal standpoint. FIT was a specialized team located within the Homicide and Robbery Division. In April 2012, citing manpower issues, the Homicide and Robbery Division stopped using the original FIT model of one squad handling all officer-involved uses of deadly force. Instead, LVMPD reverted back to the policy of having all homicide squads handle investigations on a rotating basis.

LVMPD also established CIRT in 2010 as the need to conduct comprehensive deadly force reviews from an administrative standpoint became apparent. CIRT conducts in-depth, administrative reviews of all use of deadly force incidents. The statements and evidence obtained are for internal use only, and are used to dissect the officer's tactics, decision making, and training. CIRT presents their incident reviews to the Use of Force Review Board. The information from this investigation is used to affect training given department wide.

In 2012, LVMPD raised the level of executive involvement in the management of its Use of Force Review Board (UoFRB). The UoFRB comprises police officers and supervisors, as well as civilian members of the community. Historically, a deputy chief chaired the UoFRB, but in June 2012, the sheriff assigned the assistant sheriff of law enforcement operations as the chairman of the UoFRB. This change was designed to raise the level of accountability for all incidents being reviewed in the future.

To identify deadly force and OIS gaps, the LVMPD needed to consolidate units that deal with training and administrative investigations and ensure that lessons learned from OIS incident reviews were incorporated back into training. As a result, LVMPD consolidated these units to ensure consistent and better communication about lessons learned from deadly force incidents. LVMPD created the Organizational Development Bureau (ODB) to strengthen communications among the Quality Assurance Unit, CIRT, and the Training Bureau. This included Academy staff, Advanced Officer Skills Training (AOST), the LVMPD Firearms Range, Quality Assurance, Emergency Vehicle Operations Course (EVOC), and CIRT.

### ***New determinations***

The LVMPD determined there was a need to develop more specific use of force finding categories, in order to provide greater accountability.

The UoFRB developed new "determinations" as it relates to Use of Force findings. These included:

- **Administrative approval:** No recommendations. Objectively reasonable force was used under the circumstances based on the information available to the officer at the time. This finding acknowledges that the use of force was justified and within LVMPD policy. There are no concerns surrounding the tactics employed, and there are no policy violations including those not relating to the application of force.
- **Tactics/Decision making:** This finding considers that the tactics and/or decision making employed were less than satisfactory. Specifically designed training will be prescribed to address deficiencies.

- **Policy violation not directly related to use of force:** This finding covers a range of policy violations including but not limited to failure to qualify with a firearm, use of unauthorized ammunition, failure to carry required equipment, and related issues. A policy violation was identified but was not connected to the use of force.
- **Policy/training failure:** An outcome was undesirable but did not stem from a violation of policy or failure to follow current training protocols. An LVMPD policy and/or specific training protocol is inadequate, ineffective, or deficient; the officer followed existing policy and/or training, or there is no existing policy and/or training protocol that addresses the action taken or performance demonstrated. This finding reflects global policy or training deficiencies.
- **Administrative disapproval:** The UoFRB has concluded through this finding that the force used or action taken was not justified under the circumstances and violated LVMPD policy. This outcome is reserved for the most serious failures in adherence to policy, decision-making, and or performance.

LVMPD recently implemented an **Accountability Matrix** that will follow-up on all recommendations made by both the UoFRB and CIRT after an investigation into a critical incident. The Accountability Matrix will ensure that all recommended policy, training, or tactics changes are implemented.

### *Awareness and quarterly reports*

The LVMPD also saw a need to create a mechanism to provide its workforce with notification of timely issues that arise, after a deadly force incident. To that end, CIRT began writing and distributing an Awareness Report. The **Awareness Report** is a brief, preliminary report that provides the workforce with a general, factual summary of events known to the CIRT detectives at the time of a scene walkthrough. It references any policies, protocols, or training doctrines related to the critical incident. Since its inception, CIRT has authored and distributed an Awareness Report within 24-48 hours after a critical incident.

Finally, LVMPD determined a need to compile and maintain detailed deadly force statistics that can be used to identify trends and increase transparency. The LVMPD OIO has developed a **Quarterly Report** detailing progress made toward meeting LVMPD's mission of significantly reducing deadly force incidents.



## *Use of force policy – new concepts and parameters*

LVMPD has made substantial changes to its Use of Force Policy over the past year. These were driven by several factors, including Ninth Circuit Court rulings and an internal review process.

LVMPD updated their policy to explicitly include a “sanctity of human life” statement. The concept had traditionally been part of LVMPD training, video lessons, and classroom instruction. However, it had not been formalized into a policy statement until recently. LVMPD’s Use of Force Policy now states, “It is the policy of this department that officers hold the highest regard for the dignity and liberty of all persons, and place minimal reliance upon the use of force. The department respects the value of every human life and that the application of deadly force is a measure to be employed in the most extreme circumstances.”

LVMPD also expanded upon their guidance for what constitutes “**objectively reasonable**” use of force. This term had traditionally been explained using the three factors from the U.S. Supreme Court case, *Graham v. Connor*. Those three factors are:

1. The severity of the crime
2. Whether the subject poses an immediate threat to the safety of the officers or others
3. Whether the subject is actively resisting arrest or attempting to evade arrest by flight

LVMPD added five new factors to its policy that are meant to give their officers more contexts for decision making in use of force situations.

1. The influence of drugs/alcohol or the mental capacity of the subject
2. The time available to an officer to make a decision
3. The availability of officers/resources to de-escalate the situation
4. The proximity or access of weapons to the subject
5. The environmental factors and/or other exigent circumstances

The Ninth Circuit Court of Appeals ruling has also significantly changed the way officers will now use some of their weapons—specifically the baton (when used as intermediate force), OC spray, and the electronic control devices (ECD). LVMPD Policy now clearly puts the use of these weapons into an “**intermediate force**” category and clearly defines when these weapons are appropriate to use based on the subject’s actions.

Consequently, LVMPD revised its Use of Force model to reflect the new intermediate force category. This new model more accurately describes all of the changes previously detailed. It clearly identifies the level of force (used by officers) paired with the level of resistance (used by the suspect). It also includes the practice of de-escalation and force transition. This model is intended to give better guidance to officers on how to comply with the Ninth Circuit Court of Appeal’s analysis of Use of Force.

With regards to de-escalation as a tactic and policy, LVMPD’s policy has always defined de-escalation tactics. The policy has now been sharpened, however, to make clear that de-escalation is a method officers should consider and use in potentially violent situations. The policy also notes how important de-escalation can be and suggests ways it can be used in certain situations.

The LVMPD also determined that it needed to strengthen its policy requiring officers to intervene when observing excessive force. The revised policy states “Any officer present and observing another officer using force that is clearly beyond that which is objectively reasonable under the circumstances shall, when in a position to do so, safely intercede to prevent the use of such excessive force. Officers shall promptly report these observations to a supervisor.”

### *Rifle use*

Regarding LVMPD’s **Rifle Policy**, a number of changes were made specific to the deployment and tactical use of the rifle. These changes came in the wake of the shooting of Stanley Gibson, an unarmed subject who was shot by an LVMPD officer with a department-issued .223 caliber rifle, while sitting in his vehicle in a residential neighborhood. The policy for rifle deployment now reads:

“If there is a potential for deadly force, an officer may deem an approved rifle is appropriate based on distance, available cover, and tactical situation presented. It is important for an officer to understand terminal ballistic capabilities and limitations of the rifle to be deployed. It is incumbent on the officer to use discretion when deploying and displaying the rifle, and to only deploy the rifle when the situation dictates. The officer must also be aware of the number of rifles already deployed. Officer(s) deploying rifle(s) will: 1) Announce intent to deploy the rifle via the radio and receive an acknowledgment from dispatch; 2) Whenever possible, deploy the rifle using a two-officer team consisting of a single rifle carrier supported by a cover officer to ensure security of the scene; 3) Advise dispatch, via the radio, of deployment location and update dispatch and others assigned to the event whenever deployment location changes, thus providing situational awareness to all personnel on-scene of location of deployed rifle(s); 4) Advise dispatch, via the radio, of whether or not the deploying officer is accompanied by a cover officer; and 5) Communications will re-broadcast that a rifle has been deployed and notify the area supervisor of the deployment.”

### *Less-lethal weapons*

LVMPD made revisions to its Use of Force Policy with respect to ECDs and less-lethal shotguns, including more clarification and more restrictions on their use.

In a review of ECD usage, LVMPD’s CIRT identified that ECD deployments were problematic—the weapon often failed—consequently causing difficulty when officers tried to transition to a different weapon after the ECD failed—and officers had problems successfully handcuffing under power. CIRT and AOST personnel discovered that neither a formal process of inspection for the tool nor a consistent mandatory/hands-on annual ECD training existed. A number of changes were specifically made to the **Electronic Control Device Policy**, involving more stringent standards for the use of such devices. Significant changes included 1) defining appropriate use of an ECD, and 2) placing ECDs into the Intermediate Force category.

The revised policy now gives the following directives:

- When displaying an ECD, officers will give a warning, when practical, to the subject and other officers before firing the ECD. Officers shall give the subject a reasonable opportunity to voluntarily comply.
- Officers are not authorized to draw or display the ECD except for training and inspection, unless the circumstances create a reasonable belief that use may be necessary. The ECD will be handled in the same manner as a firearm and will be secured prior to entering any detention facility.
- The intentional use of more than one ECD simultaneously on the same subject is prohibited.
- Initial use of the ECD shall be a standard 5-second cycle, and then the officer will evaluate the need to apply a second 5-second cycle after providing the subject a reasonable opportunity to comply. Each subsequent 5-second cycle requires separate justification. Once the subject has been exposed to three cycles, the ECD shall be deemed ineffective and another use of force option will be considered, unless exigent circumstances exist.

LVMPD implemented a mandatory ECD inspection program and designed an ECD-specific training requirement of four hours annually. The class includes inspection of the ECD, classroom lecture, and scenario-based training.

LVMPD also changed policy with respect to the use and supervision of the less-lethal shotgun. The policy now identifies the level of control in which this weapon can be used. Changes to the policy also include approved and disapproved uses of the less-lethal shotgun and a requirement that officers announce a warning to the subject and other officers of the intent to deploy the weapon if the subject does not comply with commands.

### ***Moving vehicles, foot pursuit, and flashlights***

The LVMPD determined that the department should further restrict when officers could **shoot at a moving vehicle**. They established a policy that states, “Department members are not authorized to discharge their firearm, either at or from a moving vehicle, unless it is absolutely necessary to do so, to protect against imminent threat to life of the member or others. The imminent threat must be by means other than the vehicle itself.”

In early 2011, LVMPD developed a **foot pursuit** policy to establish parameters surrounding decision making and officer safety. The policy details the factors to consider when deciding to engage in a pursuit, officer safety concerns, and transitioning from pursuit to apprehension. The policy also details the roles and responsibilities of: the officer initiating the pursuit, assisting officer(s), supervisor, and dispatcher. The department distributed a training video that discussed various tactics to stay safe and alert during foot pursuits.

After a review of a critical incident in January 2011, LVMPD identified that there was no policy governing **flashlight-mounted weapons**. Therefore, LVMPD Policy was updated to read, “the only approved flashlight mounts will be those that do not affect the functionality of the weapon. It is recommended that officers contact range armorers prior to selecting a flashlight mount to ensure compatibility. Flashlight mounts must be inspected by FTTU [Firearms Training and Tactics Unit] prior to mounting.” In addition, the LVMPD Range began including flashlight techniques as part of the quarterly qualifications.

### *Public information and documentation*

To respond to calls for more transparency, LVMPD OIO authorized the release of documents related to OISs, in conjunction with the decision letters released by the District Attorney’s Office. The following documents are related to the Use of Deadly Force:

- **Homicide Report** contains evidence found by the investigating homicide detectives. These reports will be made available in their entirety on the LVMPD OIO webpage. Information deemed confidential in nature will be redacted.
- **OIO Review** includes the findings of the Use of Force Review Board and will also include any changes or additions made to policy, procedures, tactics, or training if found necessary to do so as a result of a deadly force incident.
- The **OIO Quarterly Report** details first quarter’s progress made toward meeting the mission of significantly reducing deadly force incidents.
- The **Deadly Force Statistical Analysis 2010-2011** is a statistical report used to identify trends and patterns related to the use of deadly force.

### *Training and tactics*

LVMPD has made numerous reforms to its training programs over the past two years. In October 2010, LVMPD began designing individualized training programs for officers involved in deadly force incidents who committed policy, procedural, or tactical errors. Another substantial change to the department’s training had to do with the department’s **Advanced Officer Skills Training (AOST)**. AOST is a mandatory eight-hour class given once a year to all patrol officers. This training, both classroom- and scenario-based, focuses on skills required by all patrol officers. LVMPD adjusted AOST curriculum to respond to training and tactical needs of the agency, based on a review of incidents by CIRT. Some of the areas of training the CIRT specifically impacted are:

- Use of less-lethal options
- Foot pursuit training
- Scenarios based on the principle of de-escalation
- Police on Police encounters

LVMPD also updated its AOST to include MILO, a video-based interactive decision-making program. Traditionally, LVMPD officers were not required to undergo such training while in-service; however, all police officers are now required to attend this training annually.

In another change to the training curriculum, the LVMPD determined that **Reality-Based Training** (RBT) would better prepare officers to handle dynamic situations and successfully bring them to the best conclusion. The RBT program is mandatory, semi-annual squad training for all patrol, community-oriented policing (COP), and Problem Solving Unit (PSU) sergeants and officers. RBT consists of three blocks of training: Knowledge-Based Training (classroom), Advanced Defensive Tactics, and Reality-Based Training (scenarios). RBT provides relevant training on lessons learned through classroom instruction complemented with scenario training. Since the training is now held twice a year, it can address any emerging deficiencies or challenges that LVMPD is experiencing. In addition, RBT for supervisors was designed specifically with the emphasis placed on leadership during team scenarios. Supervisors go through each scenario prior to their officers going through the training. With this structure, supervisors are scheduled to go through each scenario four times a year.

Both AOST and RBT modules have begun to focus on de-escalation tactics. In various scenarios, officers are trained to slow down the momentum of a call, get a supervisor to the scene, and consider their force options, whenever feasible.

LVMPD has also incorporated lessons learned into training videos, which reenact OIS incidents and focus on officer safety. The first video was completed in early 2011 and was distributed throughout the department. The department also produced short **Constitutional Policing** training videos for its officers on topics such as consensual stops and investigative detention/Terry stops. These educational videos focus on assisting officers in the process of making lawful decisions in the field.

In another initiative to address officer safety concerns involving police-on-police encounters with plainclothes officers, LVMPD established a mandatory in-service training class titled "Police-on-Police Encounters," for all PSUs. PSUs are plainclothes officers working in substations. The department also developed specialized unit-based training in critical incident response, as a result of a critical incident involving a narcotics squad.

In examining their training, the LVMPD determined that it needed to recertify its Crisis Intervention Team (CIT) officers. These officers regularly interact with persons suffering from mental illness. Under the CIT Recertification Program, LVMPD will train up to 400 officers per year. LVMPD plans to recertify all CIT officers on a three-year basis. The department has also made CIT certification a preferred skill for advancement in the organization. Therefore, patrol officers interested in promotion to sergeant are encouraged to complete CIT.

Because of the many changes in policy, the LVMPD determined that it needed to train every commissioned police and corrections officer on the new Use of Force Policy. As a result, the department mandated that every commissioned police and corrections officer attend a four-hour training class focused on the revisions made to the policy. All supervisors were trained on the policy prior to their officers. The training was conducted over a five-week period and covered every change to the policy, with an emphasis on:

- The sanctity of human life
- De-escalation of force
- Force transition
- New intermediate level of force

## Chapter 4: Five-Year Detailed Analysis of LVMPD, 2007–2012

This chapter details various characteristics of OISs in Las Vegas, including time, place, officers, subjects, and outcomes. It is largely a descriptive analysis, the purpose of which is to set the context for the incidents that LVMPD policies, training, and investigations are based upon. Some characteristics described here are revisited throughout other chapters as appropriate and necessary.

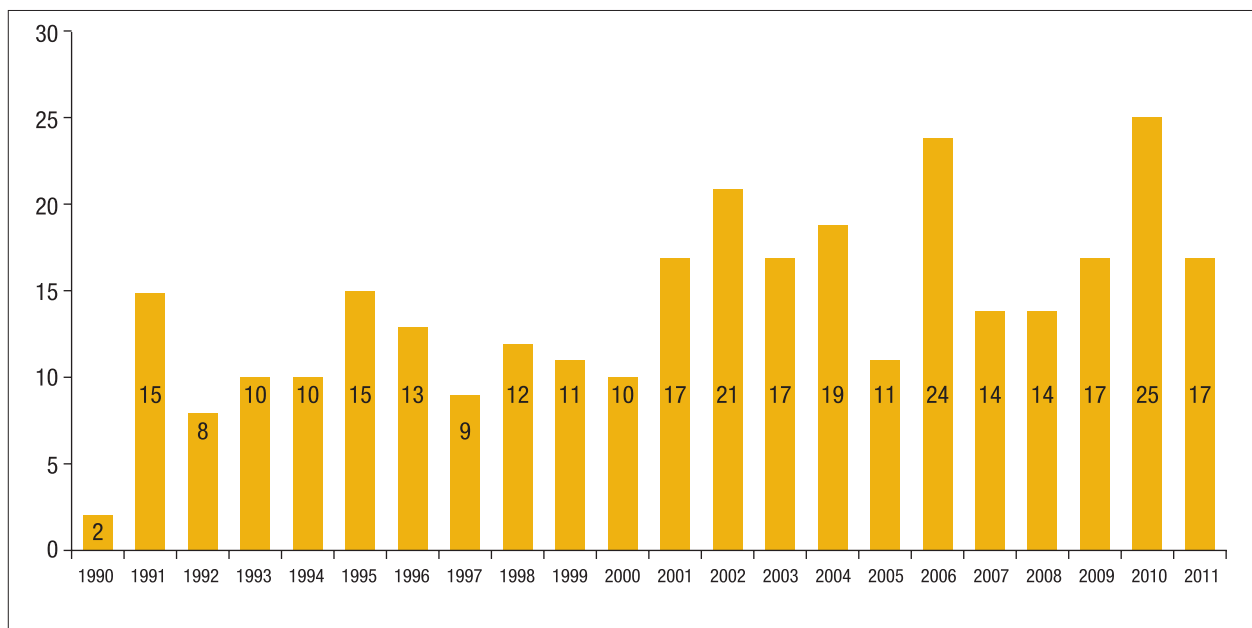
### Temporal contexts (time)

#### *Historical overview, 1990–2011*

Between 1990 and 2011, the number of OISs in Las Vegas has increased considerably, as has the population of the Las Vegas metropolitan area. In the 1990s, the number of OISs in any given year was never greater than 15 and was usually less. In 2001, the number of OISs first surpassed 15; it then often did so in subsequent years. The years 2002, 2006, and 2010 had exceptionally high numbers, each accounting for more than 20 OISs.

However, it is important to note that from 1990 to 2011, Las Vegas’s population grew from just over 600,000 residents to almost 1.5 million—an increase of approximately 134 percent.<sup>10</sup> Figures 1 and 2 (on page 34) illustrate the numbers of OISs in Las Vegas by the raw figures and per 100,000 residents, respectively.<sup>11</sup> Over the time period represented in those figures, the average OIS rate is 1.3. Although the years 2002, 2004, and 2010 remain exceptional when accounting for population size (1.8 shootings for every 100,000 residents), Figure 2 shows that the past decade, in general, has not been marked with greater OIS rates. The two years with the highest OIS rates were, in fact, 1991 (2.3) and 1995 (1.9).

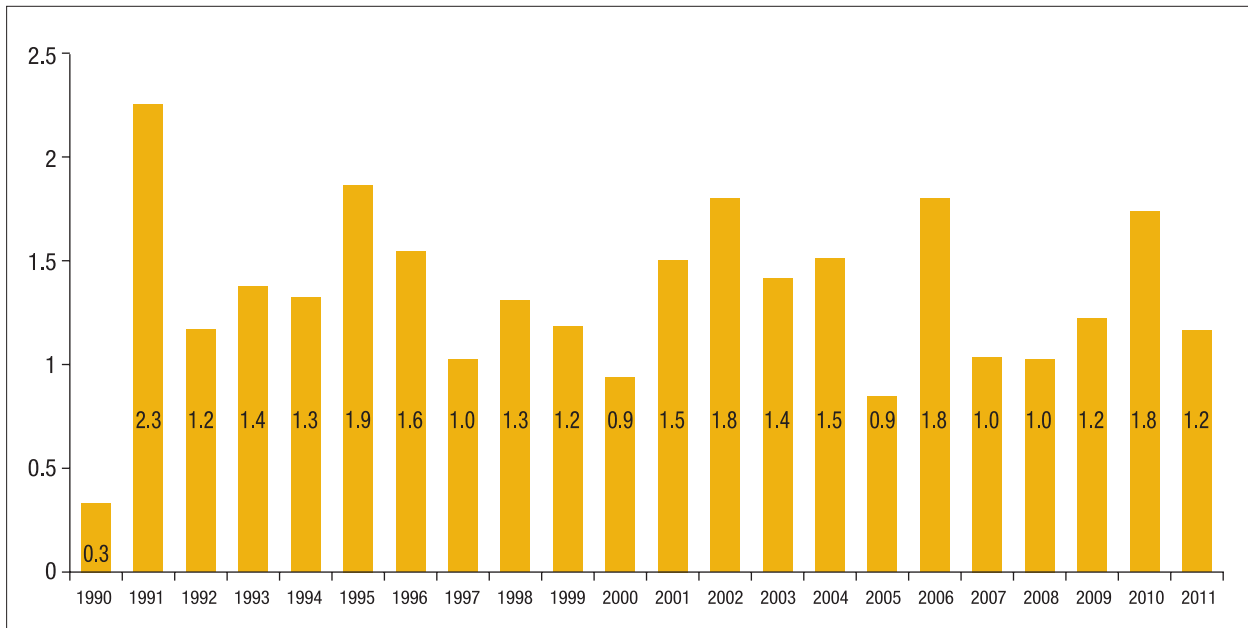
**Figure 1. Number of OISs**



10. Federal Bureau of Investigation, *Uniformed Crime Report, 1991–2011* (Washington, D.C.: U.S. Department of Justice).

11. LVMPD official statistics count 18 OISs in 2011. One incident involved two OISs that were approximately eight hours apart. We classify them as one incident.

**Figure 2. Number of OISs per 100,000 residents**



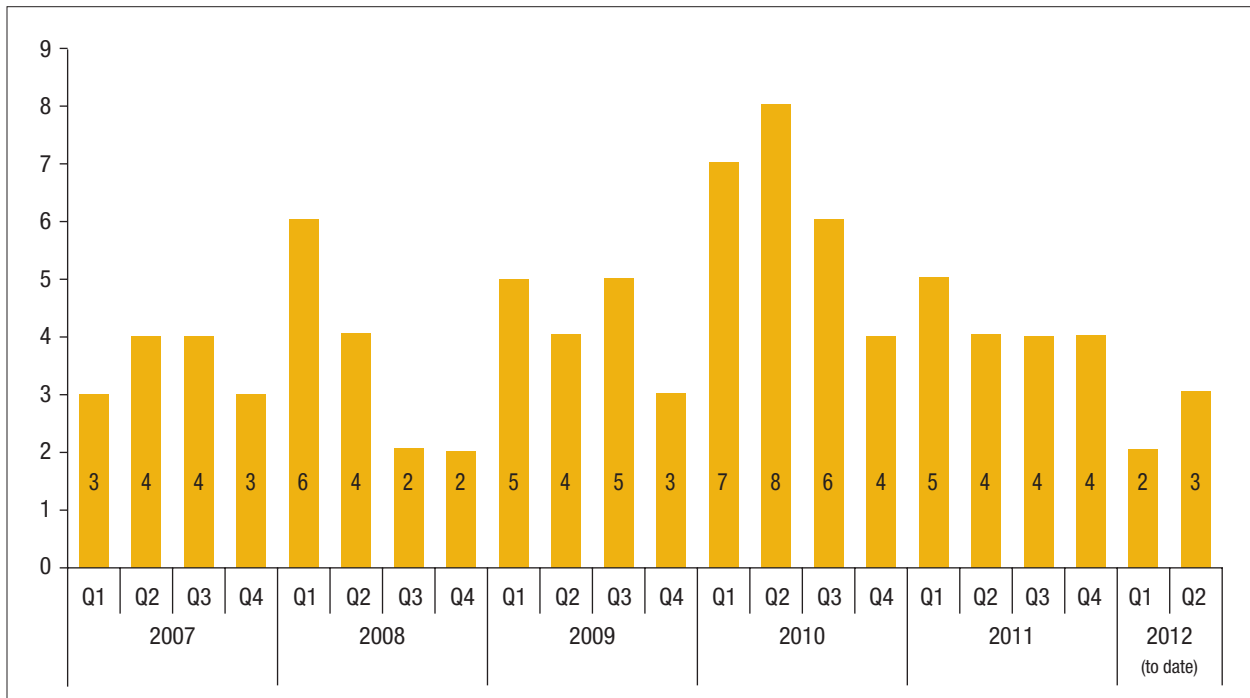
A correlation analysis of OISs and population figures over the 21-year period indicates that population growth has played a considerable role in the number of OISs by LVMPD ( $r = .68$ ). Other factors will clearly influence the frequency of OISs over time; however, evidence from LVMPD shows that population growth over time is an important control variable.

***Quarterly figures, 2007–present***

Since 2007, the number of OISs per quarter has been approximately 4.2 on average. Figure 3 on page 35 illustrates the quarterly numbers of OISs from 2007 to present day. It shows that, since a peak of 8 OISs in the second quarter of 2010, there has been a general decline to relatively normal numbers.

**Environmental/situational contexts**

Environmental and situational contexts describe the physical and social characteristics of the immediate area and interaction preceding the OIS. In short, it describes the neighborhood and under what circumstances the subject and officer were there and interacting with each other. Specifically, we describe the zip code, source of initial contact, call type, and the physical location (inside, outside, or in a vehicle) in this section.

**Figure 3.** Number of OISs by quarter

### Zip code

Twenty-six zip codes have been impacted by LVMPD OISs since 2007. All zip codes are within LVMPD's jurisdiction except one, which is in Henderson and was the location of two off-duty encounters and a SWAT standoff. Therefore, out of 77 zip codes in Las Vegas, roughly one-third ( $n = 25$ ) have had OISs in the past five years.

The zip codes most impacted by OISs have been 89103, 89108, 89115, and 89121. Together, these four accounted for 42.5 percent ( $n = 37$ ) of OISs from 2007 through 2011. They accounted for about 17 percent of the population of the Las Vegas metropolitan area in 2011. These zip codes have some of the highest calls for service for violent crimes in Las Vegas; each ranks in the 80th percentile or higher.

We analyzed the relationship between violent crimes and OISs by zip code in Las Vegas and made two significant findings. Over the five-year period, 70 distinct zip codes had calls for service for violent crimes, with a range of 65 to 67 distinct zip codes per year. In sum, there were 329 distinct zip code–year combinations from which to base our analysis of OIS and violent crimes.

We compared the number of violent crimes for zip codes with at least one OIS to those with zero OISs. On average, zip codes that had at least one OIS had approximately four times the number of violent crimes than those that did not. Table 1 shows this means comparison.

**Table 1.** Violent crime and OISs by zip code, 2007–2011

OIS N	Sample N	Average violent crimes N
One or more OIS	58	1,108.7
Zero OIS	271	274.2
Combined	329	421.3



In sum, our analysis of the dispersion of violent crime within Las Vegas' geography suggests that violent crime is a significant factor in the prevalence of OISs and their disparate impact on different zip codes.

### ***Initial contact***

The initial contact is the reason that an officer is at a particular location with a subject and engaging that subject in official police business. In other words, it is the reason the officer has encountered the subject. In our study, the majority of initial contacts originated with calls for service (65 percent).

Officers initiated the contact about 12.6 percent ( $n = 11$ ) of the time, which accounts for the second most frequent reason.<sup>12</sup> Officer-initiated contacts were most often consensual or low-level encounters. A consensual encounter is defined as "a completely voluntary police interaction with members of the public, requiring no legal justification for the interaction, where a reasonable person would feel free to disregard the police and go about their business."<sup>13</sup> However, it is important to note that, in 4 of the 11 contacts defined as officer-initiated, the officer was provoked in some way by the actions of the suspect(s) prior to the incident.

In two instances, LVMPD officers observed someone they believed to be armed. In both instances, the suspects were portraying fake guns (a BB gun in one instance and a toy gun in the other) to be real. Another OIS took place during a traffic stop and was preceded by the officer hearing gun shots in the vicinity. In another OIS, an officer was dispatched to a location for an unknown disturbance. Upon arrival, the officer heard shouting coming from a nearby garage. As the officer approached the garage, the subject aimed an assault rifle at the officer.

Accounting for these circumstances, where the officers were essentially responding to a perceived threat, we can say that the proportion of OISs that were preceded by low-level, officer-initiated contacts was 8 percent ( $n = 7$ ) from 2007 to 2011. By "low-level encounters," we are referring to cases involving jaywalkers or consensual encounters that escalated into violence.

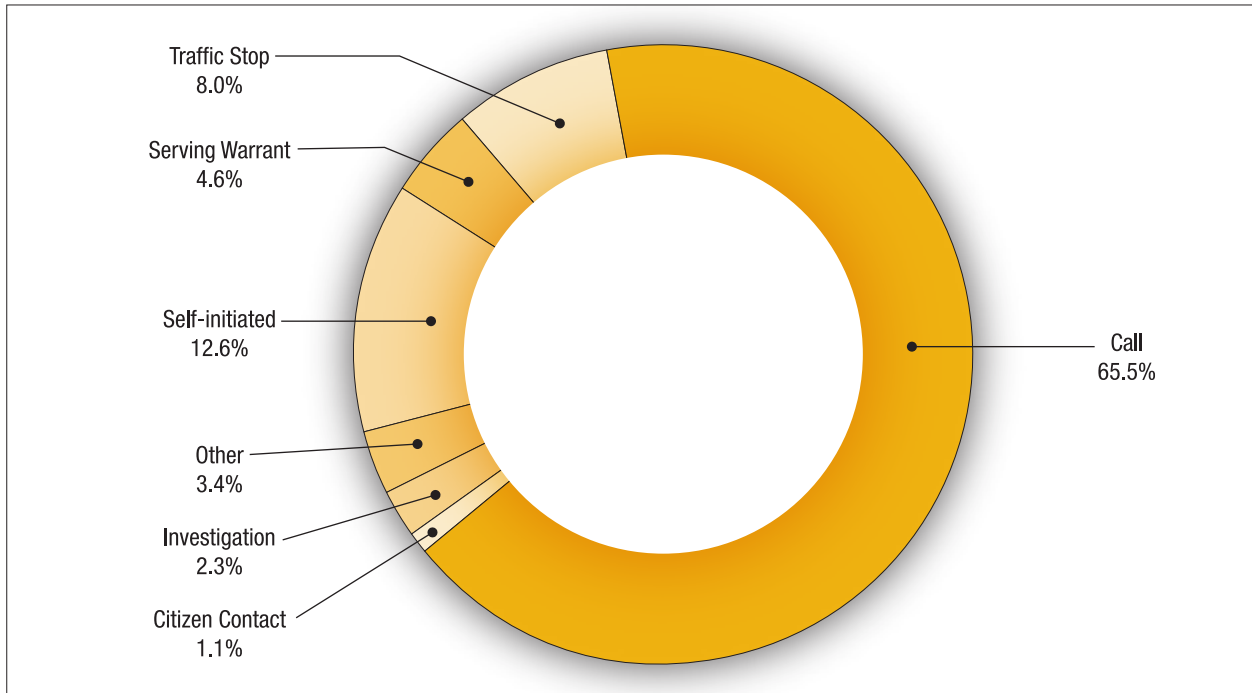
The third most frequent cause of initial contact were traffic stops (8 percent) followed by serving warrants (3.4 percent), other (3.4 percent), investigations (2.3 percent), and citizen contact (1.1 percent). The three "other" consist of the attempted robbery of an off-duty officer, a routine "checkup" of a local bar during which the officer was suddenly at gunpoint from one of the patrons, and the home invasion of an officer's home while he/she was off duty. Figure 4 on page 37 shows the proportions of initial contacts that preceded OISs from 2007 through 2011.

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12. Based on our review of the incidents, we reclassified two OISs that were previously coded as "officer-initiated" by the RJ. One case involved an off-duty officer who was approached and believed he was about to be robbed. When one of the suspects appeared to reach for a weapon, the off-duty officer fired, and the men fled the scene. We reclassified this as "other" because the officer was in fact the one who was approached and therefore could not have initiated the contact. The second case was reclassified as an "investigation." It involved an arrest made by the Sexual Assault Detail during an investigation of alleged sexual abuse.

13. LVMPD, "Section 1 Policy, Fourth Amendment, Definitions," *LVMPD Policy Manual* (no date).

**Figure 4.** Initial contacts that preceded OISs, 2007–2011



### Call type

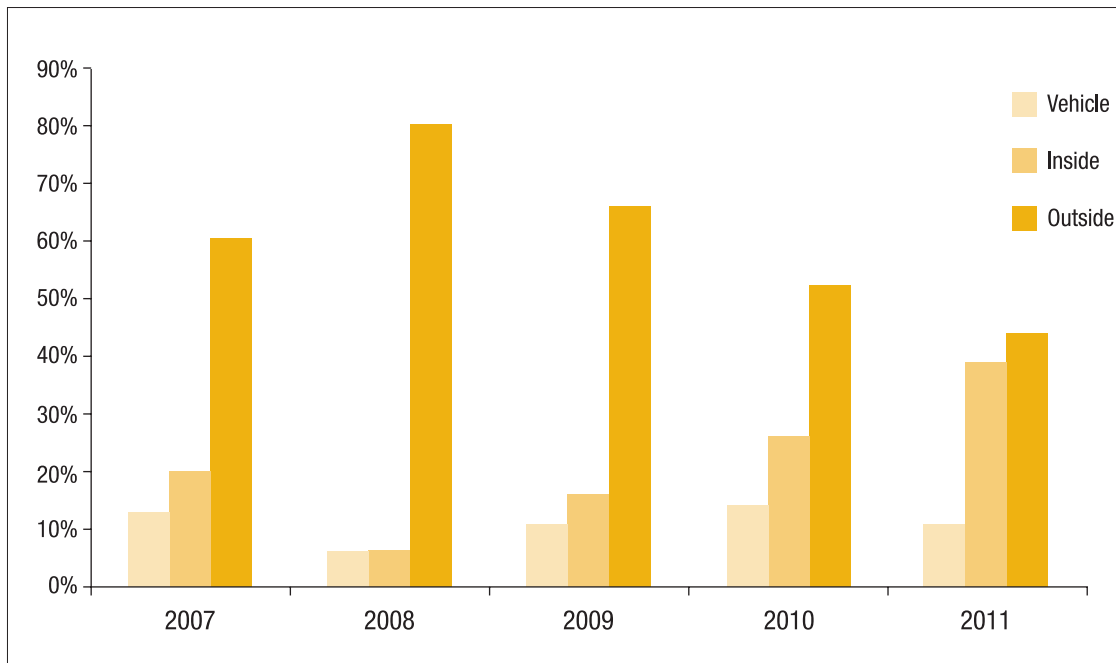
A total of 57 OISs were preceded by a call for service (CFS). These calls were broken down into 13 different types. The most prevalent call types were: 35.1 percent were for a domestic disturbance; 15.8 percent were for an armed person; and 12.3 percent were for an illegal shooting. Table 2 shows the breakdown of call types preceding OISs from 2007 to 2011. It also provides the total number of calls for service for each call type during that time period as a benchmark.

Domestic disturbance calls were the most frequent call type preceding an OIS. However, this is primarily due to their frequency in calls for service in general. The rate shows that domestic disturbance calls are, in fact, less likely to result in an OIS than many other types of calls. Looking at the rates, we can see that the call types most likely to result in an OIS were “person with a gun, knife or other weapon,” “illegal shooting,” and “kidnapping.”

**Table 2.** Call type preceding OISs, 2007–2011

Call type	N	% of all OIS	CFS	Rate per 100k CFS
Domestic disturbance	20	35.1	278,523	7.2
Person with gun, knife, or other weapon	9	15.8	22,190	40.6
Illegal shooting	7	12.3	18,754	37.3
Robbery	5	8.8	45,159	11.1
Burglary	3	5.3	352,895	0.8
Suicide	3	5.3	38,355	7.8
Unknown trouble	3	5.3	290,653	1.0
Suspicious person	2	3.5	180,611	1.1
Assault	1	1.8	100,061	1.0
Assist an officer	1	1.8	17,803	5.6
Kidnapping	1	1.8	3,001	33.3
Prowler	1	1.8	7,991	12.4
Sexual assault	1	1.8	7,829	12.8

**Figure 5. Location of OISs**



### *Physical location*

As shown in Figure 5, most OISs (63 percent) have occurred outside. They occurred inside 24 percent of the time and were “vehicle OISs” 13 percent of the time (a vehicle OIS is an incident where the officer shot into or at a vehicle).<sup>14</sup> In recent years the proportion of shootings occurring outdoors has generally declined; conversely, the proportion of shootings indoors and into vehicles has risen. In the latest full year of data, shootings occurring inside hit a five-year high of 41 percent of total OISs (n = 7).

One-third (33 percent) of OISs occurring indoors were preceded by domestic disturbance calls—more than any other call type. Most vehicle OISs were not preceded with a call for service, but rather were the result of proactive enforcement activity; an investigation and a warrant preceded one vehicle OIS each.

### **Officer characteristics**

This section describes the officers that were involved in OISs between 2007 and 2011, including the number of officers involved, and the age, tenure, rank and division of each. An important distinction here is that “officers-involved” refers to officers who fired their weapon, whereas “officers on-scene” refers to officers who were on-scene at the time of the incident. When we cite “officers on-scene,” we mean the total number that had accumulated up to the time of the OIS.

14. All vehicle shootings were technically outside; however, we parse these out for their qualitative difference from all other outside shootings.

### *Number of officers on-scene*

The number of officers on the scene of an OIS varied widely, ranging from just one to 23, with an average of 4.4 per incident. The most common number of officers was two, followed closely by three (see Table 3). Half of all incidents had three or fewer officers.

OIS incidents that occurred while LVMPD was serving a warrant had, on average, the greatest number of officers on scene (9), while traffic stops had the fewest (2). For OISs preceded by calls for service, burglary calls had the most officers on scene, with an average of 9.7. Although it should be noted that there were just three burglary calls in the five year period, one of which turned into a standoff involving 23 officers. Calls for unknown trouble typically had the fewest officers on-scene at the time of the OIS (2.6).

### *Number of officers involved*

In 87 OISs, a total of 137 officers fired their weapons. Over 85 percent of OISs involved two or fewer officers (see Table 4 below). In approximately two-thirds of OISs, just one officer fired their weapon.

### *Rank*

Out of 137 officers who used their firearm in an OIS incident 91 percent (n = 124) were patrol officers; 9 percent were sergeants (n = 12); and less than 1 percent were lieutenants (n = 1).

At the incident level (n = 87), we found that 91 percent involved a patrol officer (n = 79), 13 percent involved a sergeant (n = 11); and 1 percent involved a lieutenant (n = 1).

However, accounting for all officers on the scene at the time of the OIS, including those that did not discharge their firearm, we found that 37 percent (n = 32) of incidents had a supervisor (i.e., an officer at the rank of sergeant or above). Supervisors tended to be on the scene of incidents where more officers were present. For example, the average number of officers on the scene when a supervisor was present was 6.3, compared to an average of 3.4 officers on scene when no supervisor was there.

**Table 3.** Number of officers on-scene of OISs, 2007–2011

Number of officers on-scene	N (OIS)	Percent
1	9	10
2	18	21
3	17	20
4	15	17
5–7	15	17
8–10	8	9
11–15	4	5
16+	1	1

**Table 4.** Number of officers involved in OISs, 2007–2011

Number of officers involved	N (OIS)	Percent
One	58	66.7
Two	17	19.5
Three	6	6.9
Four	4	4.6
Five or more	2	2.2

## *Age and tenure*

In general, the age and tenure of officers involved in shootings did not differ greatly from that of the department as a whole. In other words they were neither significantly older nor younger, nor more or less tenured than their counterparts throughout LVMPD.

Between 2007 and 2011, the average age of an officer involved in shootings was 35.1 years old, with a range from 22 to 60 years old. We compared the ages of officers involved in shootings, accounting for the differences in age groups across ranks, to the average age of the department, and found no notable differences. We accounted for different age groups within the department’s ranks as well as the changing age demographic over the years. For most years, involved officers at the rank of police officer and sergeant were slightly older on average than the department as a whole, by a margin of approximately three years. Like age, the tenure of officers involved in shootings tends to be slightly greater than that of the department as a whole, accounting for variations over different ranks and years.

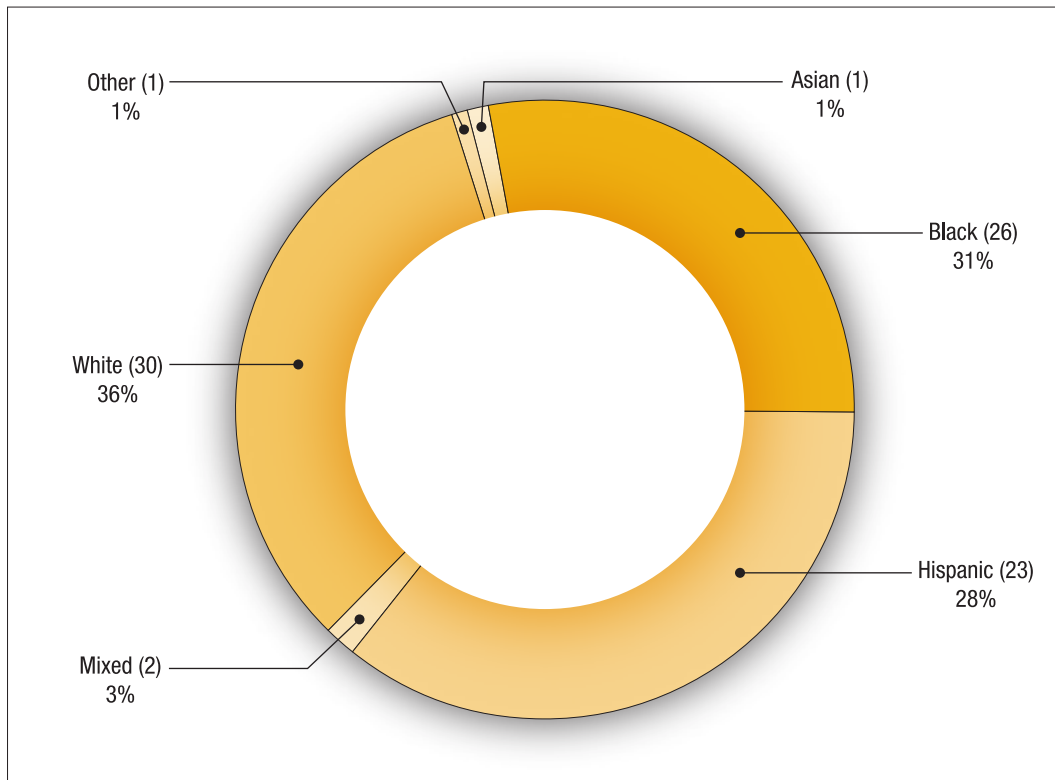
## *Assignment*

Seventy-nine percent of OISs (n = 69) involved officers of the Patrol Bureau. The rest of OISs involved officers of the Gang Crimes Bureau, SWAT, Traffic Bureau, Saturation Team, Financial and Property Crimes Unit, and Sexual Assault Detail (see Table 5 below). Two OISs involved off-duty officers.

Of all OISs involving patrol units, 75 percent were preceded by a call for service. If an OIS was preceded by a call for service, it typically involved a patrol unit (91 percent of the time). SWAT was involved in 5 OISs, including 4 calls for service and 1 while serving a warrant. OISs involving the Gang Crimes Bureau were most likely to be preceded by a self-initiated interaction, such as a consensual stop or a stop for jay-walking. Sixty percent (n = 3) of the Gang Crimes Bureau’s OISs began with a self-initiated interaction with the suspect. Two out of three (66 percent) of Traffic Bureau OISs were preceded by traffic stops. The third Traffic Bureau OIS began with a citizen contact and request for help.

**Table 5. Assignment of officers involved in shootings, 2007–2011**

<b>Assignment</b>	<b>N</b>	<b>Percent</b>
Patrol Bureau	69	79.3
SWAT	5	5.7
Gang Crimes Bureau	5	5.7
Traffic Bureau	3	3.4
Off Duty	2	2.3
Financial and Property Crimes Unit	1	1.1
Saturation Team	1	1.1
Vice and Narcotics Bureau	1	1.1
Sexual Assault Detail	1	1.1

**Figure 6.** Race and ethnicity of OIS subjects, 2007–2011

## Subject characteristics

This section describes the subjects of OISs (i.e., suspects or civilians shot) between 2007 and 2011, including demographic data and characteristics specific to the circumstances, such as whether they were armed, what they were armed with, and their state of mind. The vast majority of incidents involved just one subject (98 percent). The rest ( $n = 2$ ) involved two subjects.

### Demographics

The subject was not caught in four cases and, therefore, there is little demographic data to report on those OISs. The sex of the subject was identified in 85 cases; 98 percent ( $n = 83$ ) were male and about 2 percent ( $n = 2$ ) were female. Subjects ranged from 15 to 54 years of age; the average was 32 years old. Figure 6 displays the race and ethnicity of the subjects. It shows that most subjects were white, followed by black, then Hispanic, mixed, Asian, and other.<sup>15,16</sup>

The reason for the initial contact was not evenly distributed across racial and ethnic groups. For instance, two-thirds ( $6/9$ )<sup>17</sup> of the OISs preceded by self-initiated interactions involved black suspects. Self-initiated interactions also made up almost a quarter of all OISs involving black suspects.

15. In the two cases where there were two subjects, the subjects were of the same race and ethnicity. The proportions represented in Figure 6 are measured per incident. Therefore, for the purpose of this analysis, the two-subject OISs are collapsed into one incident each involving each respective race and ethnicity.

16. The identities of four suspects are unknown: two because they were juveniles, and two because they fled the scene and were not found.

17. The race and ethnicity of two self-initiated interactions is unknown.

**Table 6. Suspect weapon during OIS, 2007–2011**

Weapon	N	Percent
Gun	50	57.5
Knife or sword	12	13.8
No weapon	11	12.6
Fake gun <sup>a</sup>	4	4.6
Reached for officer's gun	3	3.5
Vehicle	3	3.5
Bat or stick	2	2.3
Screwdriver	1	1.2
Unloaded shotgun found in vehicle <sup>b</sup>	1	1.2

a. Fake guns include one BB gun and a makeshift fake gun.

b. We found one case to be indeterminate. An officer heard gun shots and pulled over a suspect who was later found to be the source of the gun fire. The officer saw the barrel of a gun coming from the suspect's right hand and fired one round toward the suspect. An unloaded shotgun was recovered from the backseat of the vehicle.

## Weapons

Table 6 shows our analysis of the suspect's threat (i.e., what they were armed with) in all OIS incidents from 2007 through 2011. In 87 percent of OIS incidents, the subject either was armed or portrayed himself/herself to be armed with a deadly weapon. In the cases where the subject was not armed (n = 11), subjects were either physically aggressive or made a furtive movement that the officer(s) perceived as reaching for a gun or other deadly weapon.

Of the 11 cases involving unarmed suspects, 36 percent of the suspects (n = 4) were approached as the result of a call for service, and 27 percent (n = 3) were approached on the basis of self-initiated interaction by the officer. In the remaining 4 shootings of unarmed suspects, the initial contact was made by an off-duty officer in 1 case, was due to a warrant in 1 case, and resulted from traffic stops in 2 cases. In all 11 OISs of unarmed suspects, just one officer was shooting.

A greater proportion of officer-initiated interactions resulted in OISs involving unarmed subjects (27 percent) than did all other bases combined (10 percent).<sup>18</sup> In other words, the odds that the subject is unarmed are greater when the initial contact is officer-initiated.

Of the unarmed suspects whose race and ethnicity was identified (n = 10), the distribution was disproportionate. Seventy percent (n = 7) of unarmed suspects were black; 20 percent (n = 2) were Hispanic; and 10 percent (n = 1) were white.

## Substance use and mental impairment

Approximately 38 percent of all cases involved suspects who were known to be either under the influence of a controlled substance or mentally ill, as discerned from LVMPD homicide reports provided to the *Las Vegas Review Journal* (RJ). Twenty-one percent (n = 19) were under the influence of a controlled substance, the most popular being marijuana (15 percent), followed by methamphetamine (7 percent), cocaine (2 percent), and PCP (1 percent). Approximately 15 percent (n = 13) were under the influence of alcohol at the time of the OIS. Eleven percent (n = 10) of suspects were under the influence of prescription medication, such as painkillers. In addition, 3 percent of cases (n = 3) involved suspects who were known to be either suicidal or mentally ill.

18. All other bases include calls for service, warrants, traffic stops, investigations, citizen contacts, and other.

## Outcomes

This section describes the various outcomes of these incidents. In some incidents, officers used less-lethal tools in attempts to de-escalate the situation or gain the subject's compliance. In some cases, officers made tactical errors. In some cases, injuries occurred; and in others, there were fatalities. In addition to descriptive analyses, this section explores relationships among OIS variables, including incident, officer, and suspect characteristics and how they impacted the outcomes described here.

### *Less-lethal force*

In about 15 percent ( $n = 13$ ) of OIS incidents, a less-lethal option was deployed in an effort to gain compliance. Usually it was deployed prior to the shooting itself; however, in two cases, an electronic control device (ECD) was deployed afterwards. In three cases, more than one less-lethal tool was applied. Table 7 shows the frequency of each less-lethal option being used during an OIS. Of the five less-lethal shotgun deployments, two deployments also involved the use of ECD and one involved the use of a flash bang, which is a device that is designed to disorient its targets with a loud explosion and flash of light.

Less-lethal devices were not used in any OISs where a single officer was on the scene. Out of the 17 OISs where there were three officers on the scene, 29 percent ( $n = 5$ ) involved a less-lethal tool, which was the highest percentage among all on-scene officer group sizes.

A less-lethal device was never deployed when the suspect was using a vehicle as a weapon. When officers faced a suspect with a gun or a fake gun, they deployed and used a less-lethal device 7 percent of the time ( $n = 4$ ). When officers faced a threat from a sharp object (e.g., knife, sword, or screwdriver), they used a less-lethal option 23 percent of the time ( $n = 3$ ). Officers used a less-lethal option in 18 percent of cases where the suspect was found to be unarmed ( $n = 2$ ). In both cases where the suspect was armed with a bat or stick, officers deployed and used a less-lethal tool.

**Table 7. Less-lethal force options used in OIS, 2007–2011**

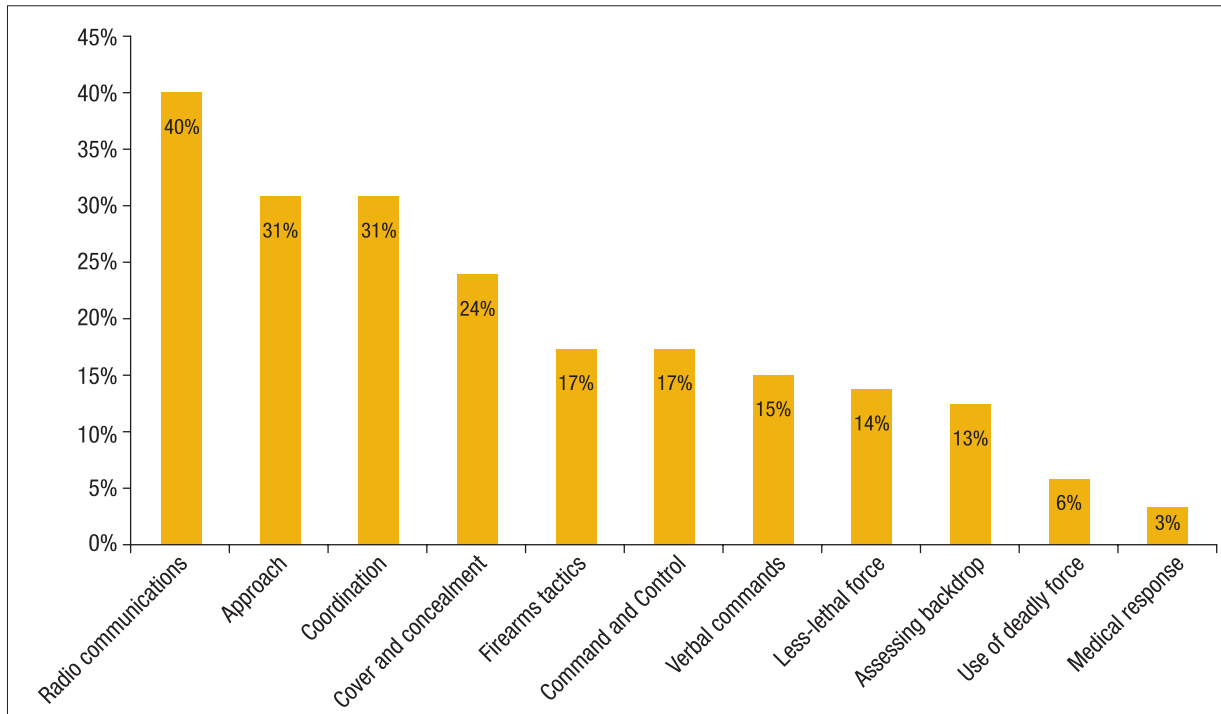
Tool	N	Percent
Flash bang	1	1.1
Less-lethal shotgun	5	5.7
ECD	10	11.5
Pepper Spray	1	1.1



## *Tactical errors*

To identify tactical errors, we used the CIRT administrative reports, which categorize tactical findings into 11 areas. Administrative reports in earlier years (i.e., CIRP reports) did not use this structure of tactical findings. For those cases, we coded such findings based on the text provided in those reports. Below, we list the tactical areas and give specific examples to define them. However, we stress that the existence of these errors should not be interpreted as OISs that could have been prevented. Simply put, these are areas for improvement identified by LVMPD's administrative investigation:

- **Radio communications** (e.g., officers covering communication by speaking at the same time; failing to update dispatch; using the wrong channel; not announcing actions over the radio; not using radio to communicate with officers en-route; or having miscommunication with the dispatcher)
- **Officer approach** (e.g., not recognizing the situation type; not forming a perimeter; having too few officers; closing the distance unnecessarily; not slowing the action; or not having proper equipment)
- **Coordination** (e.g., officers not planning actions together; roles not clear; poor handling of the suspect; or not using contact and cover)
- **Cover and concealment** (e.g., not making the best use of cover; or placing oneself in a tactical disadvantage)
- **Firearms tactics** (e.g., not announcing the deployment of a rifle; using an unauthorized firearm; aiming inappropriately; using the wrong ammunition; or using poor technique)
- **Command and control** (e.g., not establishing a command post; officers not being accounted for; supervisor not on scene; intelligence not being used effectively; or lack of clarity in roles)
- **Verbal commands** (e.g., commands unclear; multiple officers giving commands; or no verbal warning of use of force)
- **Less-lethal force** (e.g., less-lethal option not considered; less-lethal tool not being carried; intent to use not communicated to the suspect; or using the tool unnecessarily)
- **Assessment of backdrop** (e.g., backdrop not assessed; target not identified; or crossfire)
- **Use of deadly force** (e.g., force was disproportionate; imminent threat was questionable; or preclusion was not met)
- **Medical response** (e.g., not on standby; assistance not immediately requested; or aid not rendered)

**Figure 7.** Frequency of tactical errors in OISs, 2007–2011

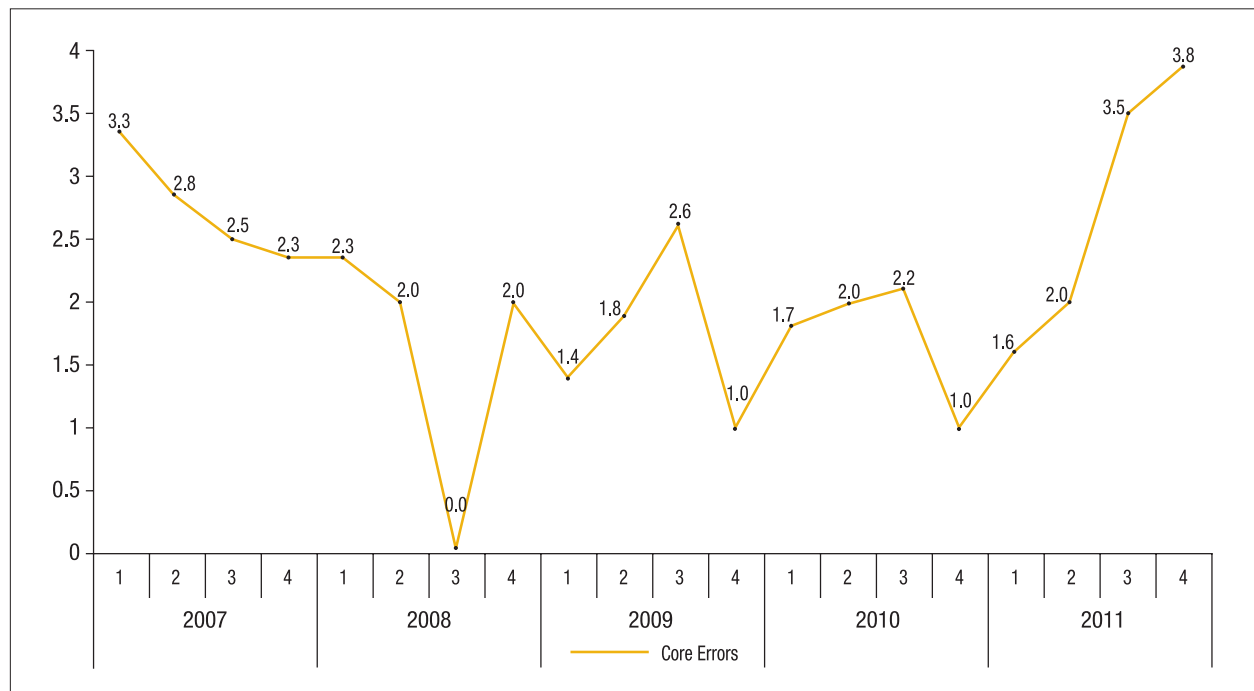
Errors in radio communications were the most prevalent. Radio communications were flawed in 35 out of 87 incidents, or 40 percent of the time. Just two of these incidents involved radio malfunctions. More likely, OIS incidents with communications flaws meant that officers failed to update dispatch or communicate with other officers over the radio when necessary. The next two most frequent errors were in the officer’s approach and coordination, each exhibiting flaws in 31 percent of OISs. The most frequent types of approach errors were failure to slow the action and failure to recognize the situation properly (e.g., barricade, CIT, or other). The vast majority of coordination errors meant that officers were not planning actions together. Figure 7 shows the frequency with which each type of tactical error was made from 2007 through 2011.

We generated an additive index of tactical errors based on the categories described above. We call these *core tactical* errors. One or more error within each tactical area is equal to 1.<sup>19</sup> Therefore, the maximum tactical index score would be 11, meaning that there was an error in each tactical area.

One limitation of this index is that it is not weighted. In other words, the gravity of errors is not given consideration—rather, all errors are considered equal. Another limitation is that, taken as a whole, the incidents were analyzed by various LVMPD investigators at different points in time. Therefore, the level of scrutiny might have been more or less, depending on the investigator(s) and/or the time—that is, some investigators, or those at certain times, might have been more likely to identify tactical errors than others. In particular, LVMPD CIRT investigators indicated that there might have been more tactical errors identified in later years, due to the advent of CIRT, which formalized and mandated the administrative investigation of deadly force incidents.

19. Note that multiple errors could occur within a specified tactical area. However, our index dichotomizes the tactical areas. For instance, if multiple verbal command errors occurred, they would still only count as one error in our index. Put another way, the number of errors should be read as *number of error types*.

**Figure 8. Average number of core tactical errors per incident by quarter**



We compared the average number of core tactical errors per incident (CTEPI) for incidents investigated by CIRT and those that were investigated by CIRT’s predecessor CIRP and found they were not significantly different. The average number of errors identified by CIRP was 2.09, and the average number of errors identified by CIRT was 2.03.

The CTEPI allowed us to observe broader trends over time, as illustrated below. Overall, the average CTEPI was 2.1. Figure 8 shows the average CTEPI per quarter from 2007 through 2011.

Two patterns emerge from the figure. There was a general decline in tactical errors from the first quarter of 2007 to the third quarter of 2008. Conversely, there was a general incline in tactical errors between the fourth quarter of 2010 and the last quarter of 2011. Below, we analyze incident characteristics to help explain the variation in tactical errors.

Among call types, domestic disturbances had the greatest prevalence of tactical errors, with an average of 3.1 per incident. Taken together, all other calls combined averaged 2.1 tactical errors per incident. Issuing proper and effective verbal commands was found to be a challenge for LVMPD when responding to domestic disturbances. Among all OISs where verbal commands were insufficient, 46 percent (i.e., 6 out of 13) were domestic disturbance calls.

Traffic stops had on average 1.1 tactical errors, the most common being the failure to make the best use of cover and concealment. Among all reasons for initial contact, serving a warrant had the greatest average number of tactical errors, 3.7. OISs resulting from self-initiated encounters tended to have fewer tactical errors than calls for service, with an average of less than one per incident.

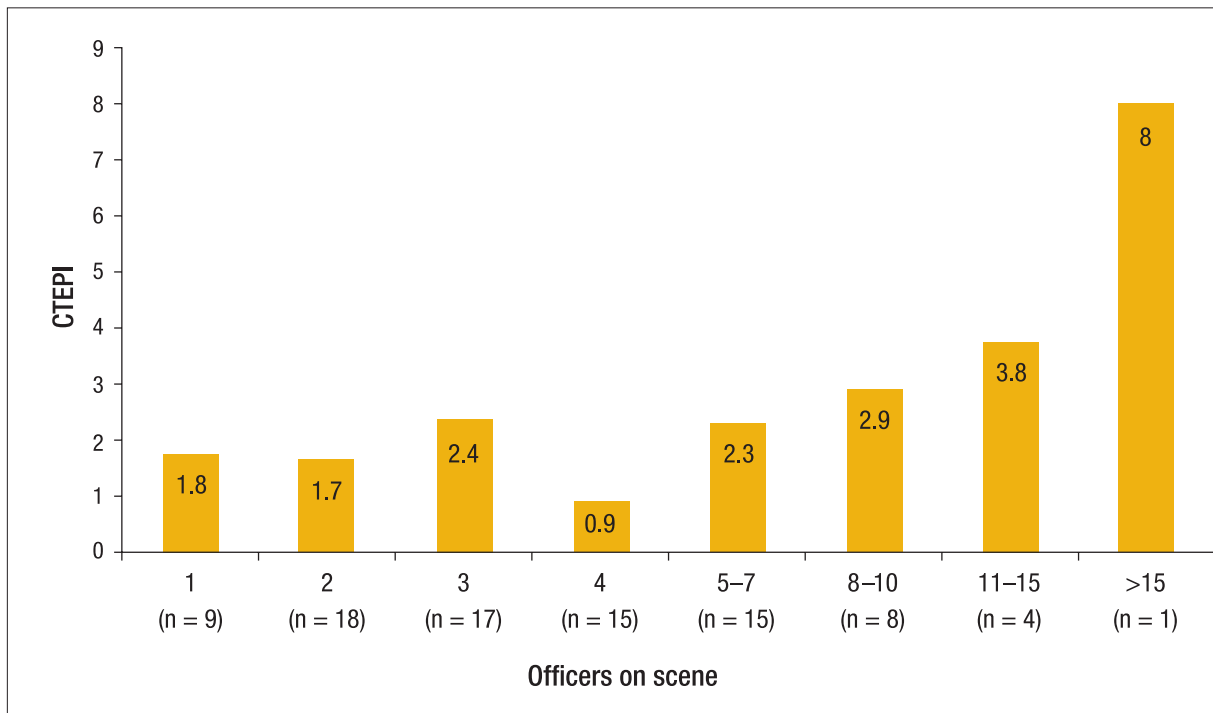
**Figure 9.** Number of tactical errors by number of officers on scene

Figure 9 shows the average number of tactical errors by total number of officers on the scene. It shows that the lowest rate of error occurred when there were four officers on the scene. The highest number of officers on a single scene was 23, which is represented in the “>15” column, and this occurred just one time. However, that incident also accounted for more tactical errors than any other incident. Looking at Figure 9, we can also see that, beginning with incidents with four officers on-scene, the average number of tactical errors generally increased, as the number of officers on-scene increased.

We dichotomized the number of officers on the scene based on the average of 4.4 and found that having five or more officers on the scene increased the number of tactical errors on average. Table 8 below shows the average number of tactical errors for incidents with fewer than five officers on the scene, and with five or more. When five or more officers were on the scene, the average number of tactical errors was 2.9, compared to 1.7 when fewer than five were on the scene.

By examining this issue more granularly, we found that specific tactical areas were driving the disparity shown in Table 8. We found that four tactical error types had a greater rate of incidence when there were five or more officers on the scene. Those error types were radio communications, officer approach, firearms tactics, and command and control. Table 9 on page 48 shows their rate of error for incidents with fewer than five officers on the scene and with five or more officers on the scene. The magnitude of difference varies but is generally double or more the rate of error when five or more officers are on scene.

**Table 8.** Tactical errors and the number officers on the scene

Officers on scene	Incidents (N)	Average number of tactical errors
Fewer than five	59	1.7
Five or more	28	2.9

**Table 9. Percentage of incidents with tactical error types by the number of officers on the scene**

Tactical area	Incidents of errors with fewer than five officers on scene (%)	Incidents of errors with five or more officers on scene (%)
Radio communications	32.2	57.1
Officer approach	23.7	46.4
Firearms tactics	10.2	32.1
Command and control	11.9	28.6

Breakdowns in radio communications were most often due to an overabundance of radio traffic with too many officers using the radio at once and, therefore, not being able to effectively communicate with other units (or, in some cases, with other agencies) that were on the scene or en route.

Flawed officer approaches usually meant that the officers could have done more to slow down the action of the incident by doing things such as establishing a perimeter or recognizing the situation as a barricade if appropriate. Deficiencies in firearms tactics mostly referred to poor techniques that could negatively impact safety. Examples include: aiming too low rather than at center mass; shooting out a locked door; using a firearm beyond the range of maximum effectiveness; and improperly handling firearms during the incident (e.g., while negotiating or while on phone). Command and control issues mostly stemmed from not using intelligence most effectively and failing to establish a command post to direct resources and manpower.

**Table 10. Tactical errors and the number of officer shooters**

Officer shooters	N	Average number of tactical errors
One	58	1.7
Two or more	29	2.9

The number of officers involved in the shooting itself was also a factor in the number of tactical errors made during an OIS. We found that, as the number of officer shooters increased, the average number of tactical errors increased as well. We dichotomized the incidents to those where there was one shooter (n = 58) and those where there was more than one (n = 29). We compared the average number of mistakes and, as shown in Table 10, found that the average was greater when more than one officer was involved in the shooting (2.9) than when just one officer was involved (1.7).

Table 11 on page 49 shows specific tactical areas that had a greater rate of error when an incident involved more than one officer shooter. Like all incidents in general, radio communications were the most frequent type of tactical error in incidents where there was more than one officer shooter. The next most frequent tactical error was coordination, meaning that officers did not devise a plan for approaching the scene and affecting an arrest. More officers firing their weapons meant that the frequency of crossfire was greater, which partly accounts for the disparity in the assessment of backdrop. Less-lethal force issues varied. Some officers used the device from too close of a distance, some failed to announce their intent to use it, and others did not formulate a plan to use it when it appeared to be a viable option.

**Table 11.** Percentage of incidents with tactical error types by the number of officer shooters

Tactical area	Incidents of errors with one involved officer	Incidents of errors with more than one involved officer
Radio communications	31.0	58.6
Coordination	24.1	44.8
Assessing backdrop	8.6	20.7
Use of less-lethal force	8.6	24.1
Command and control	10.3	31.0

In our analysis, the rank of officers did not have an impact on the prevalence of tactical errors in OIS incidents. However, in terms of specific tactical areas, we found that the presence of a supervisor on scene meant a significantly greater prevalence of command and control problems. This is unsurprising, given that command and control is primarily a supervisory responsibility; therefore, supervisors are more likely to be present when command and control are necessitated.

If a supervisor was one of the shooting officers, the average number of errors was lower. Table 12 shows that the average number of tactical errors when a sergeant or lieutenant was the shooter was half the amount than when there were no supervisors involved in the shooting itself. Accounting for this difference was a complete lack of tactical errors concerning the approach, use of cover, concealment, and less-lethal options.

**Table 12.** Tactical errors and rank of involved officers

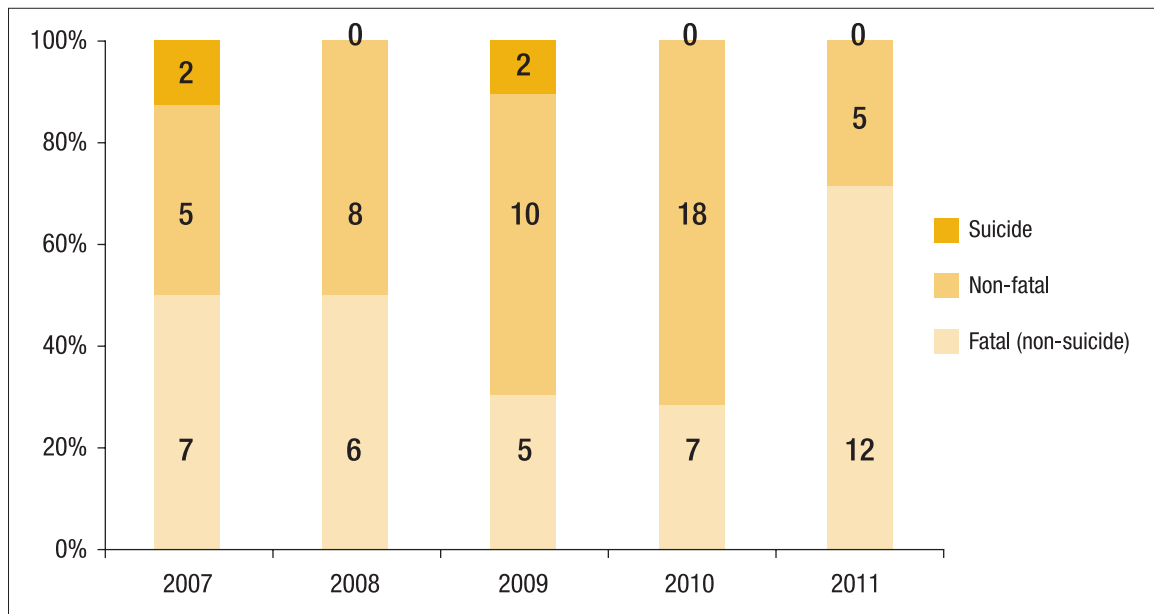
Supervisor involved?	N	Average number of tactical errors
No	75	2.2
Yes	12	1.1

We examined the average age and tenure of officers involved in shootings (i.e., officers who used their firearms). Tenure does not appear to have an impact on the prevalence of any tactical errors. However, we found some differences in the average age of officers when incidents were hampered by some specific tactical errors. Specifically, a younger group of officers, on average, tend to be involved in shootings where the approach, use of cover, concealment, and command and control could have been improved upon. Table 13 summarizes our findings. In each instance, the difference in average age is roughly three years.

**Table 13.** Average age of officers and prevalence of tactical errors

Tactical area	Average age when no error made in OISs	Average age when error made in OISs
Approach	35.7	32.9
Cover and concealment	35.5	32.4
Command and control	35.3	32.3

**Figure 10.** Outcomes of OISs



### *Fatalities*

From 2007 to 2011, OISs resulted in fatalities 47 percent of the time. Four of the fatalities were classified as suicides, meaning that the suspect themselves had inflicted a fatal injury (in all cases, a gunshot). “Suicide-by-cop” incidents are not classified as suicides for the purpose of this analysis. Figure 10 illustrates the fatality rates over time. The proportion of fatalities was highest in 2011, accounting for 72 percent of all OIS incidents.

We explored the potential factors of an OIS being fatal and found four variables that are associated with a disparate rate of fatalities resulting from OISs: number of officer shooters; number of officers on scene; number of tactical errors made; and presence of mental impairment, meaning that a suspect was under the influence of a controlled substance or was mentally unstable.

**Table 14.** OIS fatalities and significant incident characteristics

Incident characteristic	Average of non-fatal OIS	Average of fatal OIS
Number of officer shooters	1.3	2.0
Number of officers on scene	3.7	5.5
Number of tactical errors	1.7	2.6
Incidents involving mentally impaired suspects	.26	.54

Table 14 shows these incident characteristics, grouped according to whether the OIS ended in a fatality (suicides are removed for the purpose of this analysis). For instance, from the data on the incident characteristics, we find that the suspects were mentally impaired in 26 percent of non-fatal OIS incidents and 54 percent of fatal OIS incidents.

## Summary

Below, we summarize some of the key statistical findings from our analysis:

- Population growth accounted for some but not all of the variation in OISs by LVMPD.
- OISs were not evenly spread across the valley. Four zip codes in Las Vegas account for 17 percent of the total population but 42.5 percent of the OISs.
- Zip codes where one or more OISs have occurred between 2007 and 2011 had much higher (4x) violent crime rates than zip codes where no OIS occurred.
- Most OISs were preceded by calls for service (65 percent); the second most frequent precedent of an OIS was officer-initiated contacts (~12 percent).
- Although domestic disturbance calls were the most frequent type of call for service preceding an OIS, other types of calls for service had a higher rate of resulting in an OIS—specifically calls about armed persons.
- Most OISs have occurred outdoors; however, an increasing number are occurring indoors.
- The number of officers on the scene of an OIS varied widely, with an average of 4.4.
- Age and tenure of officers involved in OISs were not significantly different from the department as a whole.
- Most OISs (75 percent) involved patrol units.
- In 87 percent of OISs, the subject was either armed or portraying themselves to be armed with a deadly weapon.
- Sixty-six percent of officer-initiated interactions that resulted in an OIS involved black subjects.
- Seventy percent of unarmed subjects in an OIS were black.
- Tactical errors in radio communications were the most frequent kind of error in an OIS.
- Domestic disturbance calls had the greatest number of tactical errors on average and were associated mostly with flawed verbal commands.
- Having more officers on the scene was significantly related to the occurrence of more tactical errors.



## Findings and recommendations

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**FINDING 4.1:** The number of OISs has gradually declined since the third quarter of 2010.

The downward trend corresponds with a number of LVMPD's recent reforms, including the development of the Critical Incident Response Team (CIRT) and new Reality-Based Training (RBT) program requirement. However, the trend must be continually observed in order to assess the true impact of these programs.

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**RECOMMENDATION 4.1:** LVMPD should continue to implement reforms, monitor the progress of these reforms, and evaluate their impact on OIS incidents.

Initial data shows promise that LVMPD's reforms may impact OISs. More time and evaluation are needed to fully understand whether there is, in fact, a significant impact and, if so, how it can be sustained or revised as needed. LVMPD should develop performance metrics for its key reforms, targeting OISs, and monitor and evaluate those reforms.

However, the goal of these programs, collectively and singularly, is not just to reduce the number of OISs. They exist to educate and train the workforce and, therefore, reduce various negative incidents such as tactical errors, preventable uses of force (including deadly force), and OISs. Both officer performance and technical knowledge should be key measures of these program evaluations.

**IMPLEMENTATION STEPS:**

1. Convene key stakeholders to design performance metrics for key LVMPD initiatives.
2. Develop data collection plans for each program.
3. Reassess performance metrics periodically to ensure they are capturing the most pertinent data.
4. Analyze performance metrics to identify positive and negative trends.
5. Conduct annual reviews of programs, using performance metrics, and make adjustments as appropriate.

**FINDING 4.2:** LVMPD does not conduct department-wide fair and impartial policing training that includes a focus on use of deadly force. In addition to the community perception of biased interactions in incidents of deadly force, our review of agency data found that in seven out of 10 (70 percent) incidents where unarmed suspects were shot by LVMPD, the suspect was black. Furthermore, six of nine (66 percent) OISs that began as officer-initiated stops involved black suspects.

While comprising 26 percent of all OIS suspects, black subjects were disproportionately unarmed and disproportionately stopped as the result of an officer-initiated contact—70 percent and 66 percent, respectively. Community members we interviewed were concerned about these figures and frequently attributed them to officers operating out of fear, a lack of understanding, and inadequate training. Research using video simulations of armed and unarmed person(s), of varying races and ethnicities, have provided some evidence that unconscious racial or ethnic bias may play a role in the decision of both civilians<sup>20</sup> and officers<sup>21</sup> to shoot at a subject.

LVMPD Training Academy includes four courses that address discrimination, three of which concern police operations (the fourth is on discrimination in the workplace). One of the courses is taught by a community leader and explores various diversity issues in policing in Las Vegas. During field training, new officers take part in the Community Communications Initiative, which seeks to assist officers in identifying and understanding perceptions, stereotypes, prejudices, and different cultures. However, LVMPD does not have any advanced training modules to address fair and impartial policing. Therefore, although officers receive some early training on the topic, the span of an officer's career is mostly void of such training.

**RECOMMENDATION 4.2.1:** LVMPD should be proactive with respect to fair and impartial policing, and provide its commanders, supervisors, and officers with advanced, specialized training in fair and impartial policing.

We cannot say, from our statistical analysis, that LVMPD officers exhibit any kind of bias whatsoever. However, given the statistics we have compiled, what we learned about the perceptions of our interview participants, and what previous research has found, we believe LVMPD should proactively address this potential issue.

Training officers to become aware of unconscious biases can play a large role in how police officers interact with their community members. Over the past two years, LVMPD has been working with the Consortium for Police Leadership and Equity at the University of California, Los Angeles (UCLA) to identify and help reduce biased policing in the department. They are now working toward building cultural competency into 66 course offerings.<sup>22</sup> However, the department is not currently planning to develop specialized training in fair and impartial policing.

20. J. Correll, B. Park, C.M. Judd, and B. Wittenbrink, "The Police Officer's Dilemma: Using Ethnicity to Disambiguate Potentially Threatening Individuals," *Journal of Personality and Social Psychology* 83, no. 6 (2002): 1314–1329.

21. E.A. Plant, and B.M. Peruche, "The Consequences of Race for Police Officers' Responses to Criminal Suspects," *Psychological Science* 16, no. 3 (2005): 180–183.

22. CNA interviews.

LVMPD should initiate new training for all officers to advance fair and impartial policing. Training should promote a controlled response from the officers that overrides unconscious biases.<sup>23</sup> Considering LVMPD's lack of experience in delivering this kind of advanced training, LVMPD may work with external partners, such as the U.S. Department of Justice, to seek training initially.<sup>24</sup> For instance, the COPS Office offers a course in Fair and Impartial Policing and has conducted this training in major city police departments across the country. The training offered by the COPS Office is a train-the-trainer program and is 2.5 days long. The training the designated trainers receive will enable them to train recruits/patrol officers, supervisors, and command level staff. The training is six hours for recruits/patrol officers, 4.5 hours for supervisors, and 1.75 days for command-level staff.

**IMPLEMENTATION STEPS:**

1. Work with Human Resources/Personnel and Fiscal staff to determine the necessary resources and a means of conducting this training.
2. Identify appropriate trainers to be registered for a train-the-trainer course in fair and impartial policing.
3. Develop a training plan to train the officers, supervisors, and commanders.
4. Incorporate this training into training academy curriculum for all future hires, recruits, and supervisors schools.
5. Work with Nevada Peace Officers' Standards and Training (POST) to have the course certified for future training reimbursement.
6. Develop and approve measures of performance for the trainers, students, and supervisors.
7. Develop and implement an evaluation plan for fair and impartial policing and make appropriate changes in training delivery based on evaluations and feedback from the participants, supervisors, and training audits.

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**RECOMMENDATION 4.2.2: LVMPD should offer advanced training in procedural justice to officers at all levels of the organization and in the academy.**

There is a growing body of research showing that perceptions of fairness in police-citizen interactions impacts perceptions of police legitimacy.<sup>25</sup> To briefly summarize, when citizens believe that their contact with the police was characterized by them being treated fairly, they are more likely to respect the outcome of that interaction and have more favorable views of the police. These favorable views of the police can translate into greater legitimacy for the department and, therefore, more positive interactions with less resistance from the community they serve.

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23. L. Fridell, "Racially Biased Policing: The Law Enforcement Response to the Implicit Black-Crime Association," in *Racial Divide: Racial and Ethnic Bias in the Criminal Justice System*, ed. M.J. Lynch, E.B. Patterson, and K.K. Childs (Monsey, NY: Criminal Justice Press, 2008), 39–59.

24. See "The Fair and Impartial Policing Perspective," no date, <http://fairandimpartialpolicing.com>.

25. Committee to Review Research on Police Policy and Practices, *Fairness and Effectiveness in Policing: The Evidence*, ed. W. Skogan and K. Frydl, (Washington, D.C.: National Research Council, 2004).

As a result, this kind of training can reduce the need for police to use any force to gain compliance if needed. Numerous institutions across the United States have begun offering courses to police on procedural justice, including the Police Executive Research Forum, the Center for Public Safety and Justice, and the National Judicial College. LVMPD should offer its officers such a course by either developing their own or through another accredited organization.

### **IMPLEMENTATION STEPS:**

1. Identify procedural justice training curricula that can be offered to LVMPD officers.
2. Encourage all supervisors to take procedural justice training.
3. Work with Nevada POST to have the course certified for future training reimbursement.
4. Update training requirements to reflect procedural justice training as partial fulfillment of annual POST requirements.
5. Incorporate training into future academy classes.

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### **FINDING 4.3: Officer-initiated stops are more likely to result in a shooting of an unarmed suspect than any other type of contact.**

Our analysis shows that officer-initiated contacts precede more than 1 in 10 OISs. Our analysis also shows that OISs preceded by officer-initiated contacts are more likely to involve unarmed suspects than other bases for interaction (e.g., call for service and investigation) and that black OIS suspects are more likely to have been stopped on the officer’s initiation than non-black OIS suspects.

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### **RECOMMENDATION 4.3: LVMPD should conduct uniform training on the legal parameters of officer-initiated contacts (e.g., consensual stops and investigative detention) throughout the department, starting with proactive entities such as the Gang Crimes Bureau. LVMPD has created training videos on constitutional policing issues and the department should continue to incorporate additional training on this topic into scenario-based and role play training modules.**

LVMPD policy currently describes three levels of police interaction (e.g., consensual encounter, investigative detention, and arrest) and the justifications needed for each.<sup>26</sup> However, beyond the academy, there is no standardized training on these interactions. Given the figures from our analysis, LVMPD should re-examine its consensual stop practices and train its workforce on the legal parameters of various officer-initiated contacts—most important, consensual stops.

The training should include role-playing or field performance and can be incorporated into current training modules in AOST and RBT. The officer should be able to articulate the type of activity and level of contact they were engaged in and justifications for their responses to compliant and non-compliant subjects. This training must include consensual stops.

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26. LVMPD, “Section 2 Types of Searches, IV Definitions,” *LVMPD Policy Manual* (no date).

**IMPLEMENTATION STEPS:**

1. Engage police officer associations, legal counsel, and training staff in developing an officer-initiated activity training module.
2. Design scenarios that include consensual stops, investigative detentions, and arrests.
3. Design evaluation protocol.
4. Identify scheduling and staffing needs to ensure that the whole department is trained uniformly and in a timely fashion.
5. Update training requirements to include officer-initiated activities.
6. Educate workforce on new training requirements.

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**FINDING 4.4: LVMPD needs to better manage multiple officer situations. Tactical errors and fatalities were more prevalent when more officers are on the scene.**

The most prevalent tactical errors were found to be in radio communications. When more than five officers were on the scene, communications were often “stepped on,” meaning they were missed or unheard because multiple officers were talking over the radio simultaneously. This can hinder the ability of responding officers to coordinate a plan and approach to the scene. Multiple officers involved in the shooting also increased the likelihood of crossfire.

Command and control of the scene was the fourth most common tactical error and was significantly associated with more officers on the scene and involved in the shooting. This command and control issue corroborates with the findings of previous law enforcement studies that a lack of command and control and the coordination of officers can result in tragic outcomes and mistakes—and that this is exacerbated by too many officers being on scene.<sup>27, 28</sup>

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**RECOMMENDATION 4.4: LVMPD should ensure that supervisors and officers are prepared to handle multiple officer situations in the context of deadly force. It should use reality-based incident command scenarios to train officers on the management and direction of multiple officers during a critical incident.**

Supervisors should be able to assume management of a complex scene and position officers in a tactically advantageous way and be ready and willing to relieve officers to their regular duty when they deem sufficient resources are on the scene.

LVMPD has recently conducted a reality-based training scenario for all officers and supervisors that relates to this issue. The training allows supervisors to assume command of a scene and be evaluated on their performance. It allows officers to operate as a unit and be evaluated on their performance. LVMPD should maintain this training module and consider expanding it to include multiple squads and multiple supervisors responding to a single scene. This training can be completed as part of an officer’s AOST or RBT requirements.

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27. Independent Review Board, *The Baltimore Police Department: Police-Involved Shooting of January 9, 2011*, (Washington, D.C.: Independent Review Board, 2011).

28. New York State Task Force on Police-on-Police Shootings, *Reducing Inherent Danger: Report of the Task Force on Police-on-Police Shootings*, (New York: New York State Task Force on Police-on-Police Shootings, 2010).

**IMPLEMENTATION STEPS:**

1. Design a scenario that accounts for procedures as outlined in the LVMPD Policy Manual *Major Incident and All Hazard Plan*.
2. Develop and implement training for supervisors and officers that addresses the management and direction of multiple police officers during a critical incident.
3. Develop separate evaluation guides for assessing supervisor and officer training performance.
4. Identify scheduling and staffing needs to implement reality-based incident command training.
5. Educate workforce on new training requirements.

**FINDING 4.5: LVMPD policy does not require that supervisors respond to calls for service that involve an armed person or persons.**

Our analysis shows that calls for service involving a person with a gun, knife, or other weapon had the highest rate of OISs. In practice, supervisors were on the scene in 32 percent of all OISs. They were more likely to be on the scene (44 percent of the time) for calls for service involving an armed person(s). However, this means that most OISs that originated with armed person(s) calls were not responded to by supervisors in time. LVMPD policy does not currently address personnel requirements for high-risk calls for service.

**RECOMMENDATION 4.5: LVMPD should have policy that requires supervisors respond to any call for service that involves an armed person or persons.**

Some police departments have started requiring that supervisors respond to the scene when the subject is known to be mentally unstable, given the potential for violence and the need for experience and leadership in such instances.<sup>29</sup> Our data analysis shows that, among all calls for service, those involving armed persons have the highest rate of deadly force being used. These calls pose the greatest threat to officer safety and additional expertise, and oversight can ensure that they are resolved as safely as possible. Given this finding, we recommend that LVMPD set a requirement for supervisors to respond to any call that involves an armed person.

**IMPLEMENTATION STEPS:**

1. Convene executive staff and police associations to discuss this new requirement and outline confines of a new policy.
2. Establish a contingency plan for when supervisors are unavailable at the time the call is dispatched.
3. Publish a policy that requires supervisory response to calls involving armed persons.
4. Educate the workforce through training and awareness bulletins on the new requirement, including all supervisors, line officers, analysts, and dispatchers.
5. Monitor the CAD system for compliance with the new policy.

29. Police Executive Research Forum, *An Integrated Approach to De-Escalation and Minimizing Use of Force*, (Washington, D.C.: Police Executive Research Forum, 2011).



## Chapter 5: Use of Force Policy and Procedures

The goal of this chapter is to assess whether LVMPD policies and practices ensure that its officers use deadly force as defined by federal and state law, and in accordance with national standards and best practices. We first examine the background and common components of a model use of force policy. We then review LVMPD's recently revised Use of Force Policy, noting the recommendations and suggestions provided by the ACLU. We follow this background review with a list of relevant findings and recommendations.

### Background

The 4th and 14th amendments of the U.S. Constitution provide the basis for deadly use of force policies in the United States. Federal court guidelines stem from the benchmark 1985 decision of the U.S. Supreme Court in *Tennessee v. Garner*. This ruling held that the Tennessee statute that permitted police officers to use deadly force in arresting non-dangerous fleeing felons was unconstitutional. This ruling sanctioned the use of deadly force only as a means to “protect the officer and others from what is reasonably believed to be a threat of death or serious bodily harm,” (or) “if it is necessary to prevent the escape of a fleeing violent felon whom the officer has probable cause to believe will pose a significant threat of serious physical injury to the officer or others.” To assist law enforcement agencies in developing policies consistent with U.S. Court decisions, the International Association of Chiefs of Police (IACP) formulated the following language for its model use of force policy: “Officers shall use only force that is objectively reasonable to bring an incident under control.”<sup>30</sup>

In addition to making policy changes, many policing agencies developed comprehensive approaches to training their officers on how and when to use force, including a use of force model. These graphic models provide guidance to officers on levels of force to apply based on levels of resistance presented by the suspect. A recent survey of use of force policies showed that most policing agencies use some type of force model, many of which rely on a linear design.<sup>31</sup> However, there is no standard practice and no evidence exists for the effectiveness of one model over another.<sup>32</sup>

The IACP national model policy identifies two general circumstances in which the use of deadly force may be warranted. The first instance is “to protect officers or others from what is reasonably believed to be a threat of death or serious bodily harm.” Secondly, police officers may use deadly force to prevent the escape of a deadly felon who the officer believes will pose a significant threat of death or serious physical injury to the officer or others. The IACP further recommends these additional considerations:

- If a decision has been made to deploy deadly force, when possible the police officer should identify him or herself and demand that the subject stop the threatening conduct.
- The officer must always consider the potential risk to innocent bystanders.
- The officer must never fire warning shots.
- The officer must not discharge firearms from a moving vehicle, except in exigent circumstances and in the immediate defense of life.

30. International Association of Chiefs of Police, *Use of Force: Concepts and Issues Paper*, (Alexandria, VA: International Association of Chiefs of Police, 2011).

31. W. Terrill, E. Paoline, and J. Ingram, *Final Technical Report: Assessing Police Use of Force Policy and Outcomes*, (Washington, D.C.: National Institute of Justice, 2012).

32. Ibid.



## ***LVMPD's Use of Force Policy***

In an effort to address the community's concern over the number of OISs and the lack of police accountability, LVMPD conducted a review of all policies, training, and procedures related to use of force. As a result of this review, LVMPD Office of Internal Oversight (OIO) initiated an update to its Use of Force Policy. Many of the revisions were in line with recommendations made by the ACLU in its report, *Proposed Revisions to the LVMPD Use of Force Policy*. The report was released in March 2012 and included a review of LVMPD's Use of Force Policy and recommendations for revisions based on the ACLU's review of policies from law enforcement agencies across the country. The ACLU report concluded that LVMPD's Use of Force Policy fails to emphasize the importance of human life above use of force and that directives on use of force are not specific enough and, therefore, inadequate.

Below we list some of the substantial additions to LVMPD's Use of Force Policy:

- The addition of a mission statement that emphasizes the sanctity of human life.
- The modification of use of force based on a person's level of resistance, and the importance of de-escalating the situation once the threat of resistance has dissipated.
- The restriction on repeated, continuous, and/or simultaneous exposure to electronic control devices (ECD).
- The requirement to report all ECD activations, including unintentional ones.
- The addition of "elements of deadly force" and including the act of preclusion, which requires consideration of less-lethal alternatives.
- The revision to the definitions of "levels of resistance" and "levels of control."
- The definition of and clear emphasis on de-escalation as a tool to gain compliance without using force.
- A requirement for officers to announce the intent to use a less-lethal shotgun and not to utilize when shooting through glass or other similar mediums.
- A requirement for officers to announce the intent to deploy a rifle via radio and receive acknowledgement from dispatch.
- A requirement to re-broadcast communications on the deployment of a rifle and to notify the area supervisor of the deployment.
- The limitation of a subject's exposure to three cycles of ECD and, if the application is deemed ineffective, a requirement for the officer to consider another use of force option.
- A requirement for supervisors to direct tactics, weigh the threat, evaluate the appropriateness of using a rifle, and consider the number of rifles deployed.

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## Findings and recommendations

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### **FINDING 5.1: LVMPD's current Use of Force Policy complies with constitutional standards and model guidelines.**

The previous policy failed to clearly define essential terms such as “intermediate level of force” and “objectively reasonable force;” to include a force model that clearly depicted how a suspect’s level of resistance relates to the level of force used by an officer; to provide a “reverence for life” statement; to include an officer’s duty to intervene; and to highlight the importance of de-escalation.

LVMPD’s revisions, including some of the recommendations noted by the ACLU, are a clear sign that the department is committed to working with community stakeholders to change the culture of the department and provide officers with more guidance on the use of force. LVMPD’s revision to the policy provides officers with more extensive guidance and, most important, addresses the areas in which the previous policy fell short. The deadly force elements in the revised policy promote the goals of reducing the numbers of preventable OISs, changing the organizational culture, and enhancing officer safety.

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### **RECOMMENDATION 5.1: LVMPD should review and update its Use of Force Policy at least annually and as needed to incorporate recent court decisions, analysis of use of force data, and lessons learned from incidents in Las Vegas and other jurisdictions.**

Although LVMPD has made significant strides in improving its Use of Force Policy and initiating change within its organization, the department should routinely reassess and update the policy by analyzing OISs in Las Vegas and in other jurisdictions, and incorporating lessons learned. The review process should consist of three components: post use of force assessments, annual assessments, and assessments resulting from major court decisions. The policies and procedures for conducting these assessments should be incorporated into the LVMPD Policy Manual, which currently lacks this information.

### **IMPLEMENTATION STEPS:**

1. Formalize the policies and procedures for the Office of Internal Oversight in the LVMPD Policy Manual chapter that reviews the organization.
2. Formalize the annual review and update process in the LVMPD Policy Manual.

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**FINDING 5.2: The new Use of Force Policy is comprehensive. However, the format is cumbersome and not structured in a clear and concise manner that allows officers to quickly apply guidance in the field.**

In LVMPD's effort to be comprehensive and address a wide range of concerns, the policy became substantially more complex. While its content is in compliance with federal and state constitutional standards, the presentation of the policy is not concise. The revised Use of Force Policy is 23 pages long. In addition to its length, it includes procedural detail, such as firearms maintenance and reporting requirements. The length and the complex detail may make it difficult for officers to absorb the critical elements on the use of deadly force and apply it in making split-second decisions on whether or not to use deadly force.

An officer can take no action that is more consequential than the application of deadly force against a citizen. The IACP's model use of force policy suggests making deadly force policies brief and concise in order to facilitate understanding and application. This model policy is two pages long and notes that it is important for officers to completely understand and accurately recall knowledge of their policy in situations when deadly force is used. The IACP argues that the longer and more complex the policy is, the less likely this is to be possible.<sup>33</sup>

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**RECOMMENDATION 5.2: LVMPD should separate its Use of Force Policy into several smaller policies. This should include a core policy that serves as the foundation for the other related policies. Examples of stand-alone policies include rifles, shotguns, and other firearms; ECDs; less-lethal shotguns; batons; OC spray; and other less-lethal weapons.**

We recommend summarizing from the 23-page Use of Force Policy those components that directly relate to the application of deadly force and developing a short, concise statement crafted in a way to maximize understanding of the underlying principles for deadly force application. Additionally, the department should develop standalone policies for specific uses of force such as ECD, less-lethal shotguns, and rifle deployments. Policies on using these tools should not be combined into one, general use of force policy. Providing multiple venues for learning the complexities of the policy will ensure that all officers understand and comprehend the new policy.

**IMPLEMENTATION STEPS:**

1. Ensure essential elements are included in the core Use of Force Policy.
2. Draft specific stand-alone policies.
3. Develop an education and dissemination plan to ensure continued understanding and adherence to the new reforms.

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33. International Association of Chiefs of Police, *Use of Force: Concepts and Issues Paper*, (Alexandria, VA: International Association of Chiefs of Police, 2012).

## Chapter 6: Use of Force Training and Tactics

After graduating from the police academy, officers in major city police departments typically undergo various types and modes of training throughout their career. This in-service training provides police with both basic and advanced technical skills and tactics needed to perform their professional and constitutional duties as officers of the law and servants of the community. Large police departments often offer various voluntary training opportunities for officers seeking to specialize in a particular area of law enforcement and further refine basic skills learned in the academy. Additionally, officers are typically required to attend mandatory training on a scheduled basis. Overall, these training activities form the foundation of an officer's professional and tactical acumen. Police leaders have acknowledged that improper uses of force, including OISs, often stem from officers abandoning those tactics they were trained to use.<sup>34</sup>

The courts have decided that police departments can be found liable for failing to train officers.<sup>35</sup> However, in terms of use of deadly force training, police departments across the country generally have great latitude in the structure, prevalence, and content of their use of deadly force training.<sup>36</sup>

This chapter addresses a series of six in-service training programs conducted in LVMPD that can impact the prevalence and nature of deadly force incidents in the department: defensive tactics; crisis intervention training; Use of Force Policy training; electronic control device training; advanced officer skills training; and reality-based training. Below, we provide an overview and description of each. We then conclude with a series of recommendations.

### Defensive tactics

From 2007 to 2011, LVMPD officers were assaulted a total of 949 times (an average of approximately 190 times per year).<sup>37</sup> Even in 2011, which had the fewest officer assaults (n = 147), patrol officers still had roughly a 1-in-10 chance of being assaulted.<sup>38</sup> To ensure that officers can guard and prevail against such attacks, LVMPD requires them to be proficient in defensive tactics.

Defensive tactics training prepares officers to use a variety of skills and tools to defend themselves against an aggressor. These include hand-to-hand combat skills such as restraint holds, leveraged takedowns, hand strikes, handcuffing techniques, ground defense, and the lateral vascular neck restraint (LVNR). It also trains officers in the use of less-lethal tools such as batons and electronic control devices (ECD).<sup>39</sup> All sworn officers at the rank of lieutenant and below are required to complete defensive tactics training and demonstrate proficiency.

34. Police Executive Research Forum, *An Integrated Approach to De-Escalation and Minimizing Use of Force*, (Washington, D.C.: Police Executive Research Forum, 2011).

35. *City of Canton, Ohio v. Harris*, 489 U.S. 378 (1989).

36. G.B. Morrison, and T.K. Garner, "Latitude in Deadly Force Training: Progress or Problem?" *Police Practice and Research: An International Journal* 12, no. 4 (2001): 341–361.

37. Based on an analysis of the LVMPD's computer aided dispatch (CAD) system, these numbers represent calls for service that resulted in the following criminal charges: "assault on a police officer," "assault on a peace officer with a deadly weapon," "assault on a police officer," "battery on a police officer," "battery on a police officer with substantial bodily harm," and "battery on a police officer with a deadly weapon."

38. Given their assignment, patrol officers are the most likely to be assaulted. Consider that in 2011 there were 1,428 patrol officers in LVMPD. If no officers were assaulted more than one time, each patrol officer in LVMPD had roughly a 1-in-10 change of being assaulted.

39. LVMPD, "5/108.16, Defensive Tactics," *LVMPD Policy Manual* (no date).

The training is delivered by certified defensive tactics instructors (DTI) at their respective area commands. Nevada Peace Officers' Standards and Training (POST) standards state that DTIs must recertify every three years. LVMPD used this standard until 2010, when the department changed its policy so that instructors would recertify with an eight-hour course every two years.<sup>40</sup> DTIs conduct two hours of proficiency training per quarter, according to the manual developed by an LVMPD Training Committee. In addition, DTIs must conduct a minimum of two sessions of this quarterly proficiency training annually in order to remain proficient and certified.<sup>41</sup>

## **Crisis intervention team (CIT)**

It has been estimated that approximately 7 percent of police contacts in large jurisdictions involve mentally ill subjects and that 92 percent of patrol officers run into an average of six such encounters per month.<sup>42</sup> In 1988, the Memphis Police Department developed the Crisis Intervention Team (CIT) Model to help law enforcement officers safely manage situations with mentally ill and potentially dangerous subjects. It has since proliferated throughout the law enforcement community nationally.<sup>43</sup>

In 2003, LVMPD began a CIT specialized training program, aimed at responding to suspects believed to be mentally ill or showing signs of "excited delirium." The department defines excited delirium as "a state of extreme excitation usually associated with illicit drug use and manifested by behavioral and physical changes that may result in sudden and unexplained death."<sup>44</sup> The training is a 40-hour block of instruction on techniques for interacting with the suspects who are mentally ill or in an emotional crisis (e.g., excited delirium). The training is largely classroom based, but includes some practical exercises and interactions with patients at the Rawson-Neal Psychiatric Hospital of Las Vegas.

CIT officers are sworn, on-duty personnel and typically perform all of the routine functions of any other patrol officer. Their special duty status means that they will respond, if available, to calls for service that indicate that the suspect is mentally disturbed or in a state of excited delirium.<sup>45</sup> LVMPD policy gives the senior CIT officer on the scene authority to direct and manage the activities during an incident unless relieved by a field supervisor.<sup>46</sup> Officers become CIT certified on a voluntary basis; to date, nearly half (47 percent) of the department's patrol personnel are CIT certified.<sup>47</sup>

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40. CNA interviews.

41. Ibid.

42. G. Cordner, *People with Mental Illness*, (Washington, D.C.: Office of Community Oriented Policing Services, 2006), <http://cops.usdoj.gov/Publications/e04062003.pdf>.

43. M. Reuland, L. Draper, and B. Norton, *Improving Responses to People with Mental Illnesses*, (Washington, D.C.: U.S. Department of Justice, Bureau of Justice Assistance, 2010).

44. LVMPD, "6/005.00, Excited Delirium," *LVMPD Policy Manual* (no date), 708.

45. LVMPD, "6/005.01, Crisis Intervention Team (CIT)," *LVMPD Policy Manual* (no date).

46. Ibid.

47. CNA interviews.

LVMPD has recently taken steps to elevate its CIT program. In 2010 and 2011, CIT was a mandatory part of recruit training through the field training program that follows the academy. Although no academies have been scheduled for the training since 2010, the LVMPD Training Academy has formally incorporated CIT into its standardized lesson plan. Notably, the in-service training, two years of field training, and slated academy training have all used the same 40-hour course.

LVMPD initiated the CIT Recertification Program in August 2012,<sup>48</sup> and plans to recertify all CIT officers every three years. The department has also made CIT certification a preferred skill for advancement in the organization. Therefore, patrol officers interested in promotion to sergeant are encouraged to complete CIT.

## Electronic control device (ECD)

An ECD is a law enforcement compliance tool that uses electroshock technology to cause neuromuscular incapacitation (NMI). The tool has become standard issue for many law enforcement departments across the country, including LVMPD. ECDs have been associated with reducing injuries to both subjects and officers while effectively allowing officers to take subjects into custody.<sup>49, 50</sup>

LVMPD officers deployed and used their ECD in 11.5 percent (n = 10) of all OIS incidents between 2007 and 2011. Since 2007, the proportion of OIS incidents involving ECDs has declined from 4 out of 14 OISs (28 percent), to just 1 out of 17 (5 percent). In most cases, the ECD was deployed in advance of the OIS. In two incidents, ECDs were used on subjects who had been shot by the officers but were still resisting. Therefore, over the past five years there has been close to a 1-in-10 chance that an officer would have the opportunity to make an arrest using an ECD device prior to an OIS. In each of the cases cited, the ECD was deployed and either missed the target or was deemed ineffective (i.e., did not gain the subject's compliance). The effectiveness of this device can have an impact on whether the incident evolves into an OIS. Given these figures, it is imperative that officers are trained in the proper tactical use of the ECD.

All LVMPD officers at the rank of lieutenant and below must complete ECD certification and recertification requirements. LVMPD police recruits receive initial ECD training while at the academy. Officers who joined LVMPD before ECDs were part of the academy were required to receive a minimum of four hours of initial ECD training.<sup>51</sup>

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48. CNA interviews.

49. M. White, and J. Ready, "The TASER as a Less Lethal Force Alternative: Findings on Use and Effectiveness in a Large Metropolitan Police Agency," *Police Quarterly* 10, no. 2 (2007): 170.

50. G. Alpert, M.R. Smith, R.J. Kaminski, L. Fridell, J. MacDonald, and B. Kubu, "Police Use of Force, Tasers and Other Less-Lethal Weapons," *National Institute of Justice Research in Brief* (Washington, D.C.: National Institute of Justice, 2011).

51. LVMPD, "5/108.16, Defensive Tactics," *LVMPD Policy Manual* (no date).

Until recently, ECD annual recertification training was a two-hour component of an officer's eight-hour defensive tactics requirement. However, LVMPD recently doubled the initial certification and recertification requirements, requiring that officers complete an eight-hour ECD initial certification training course at the academy and a four-hour annual recertification training that is distinct from their annual defensive tactics requirements.<sup>52</sup> This change puts LVMPD's ECD hourly requirements in line with those of most agencies, according to recent research on the topic.<sup>53</sup> The training details the parameters of the Use of Force Policy dealing with ECDs and some tactical exercises on their use. It consists of both classroom-based lecture and scenario training.

## Advanced officer skills training (AOST)

Once a year, all LVMPD officers at the rank of sergeant and below must undergo advanced officer skills training (AOST). According to current LVMPD policy, the mandatory training is a nine-hour session that encompasses the following requirements:<sup>54</sup>

- One hour for quarterly firearms qualification
- Two hours for ECD recertification
- Two hours of classroom-based use of force training
- Four hours of reality-based decision-making scenarios with Simunitions<sup>55</sup>

In practice, however, officers meet their quarterly firearm requirements on their own time with an LVMPD firearms instructor, but not in AOST.<sup>56</sup> LVMPD training staff recognized that the one hour is not enough time to qualify, assess, and correct any deficiencies.<sup>57</sup> Additionally, the ECD requirement stated in LVMPD's Policy Manual is no longer either applicable or part of AOST, as it has been supplanted by the new four-hour annual ECD recertification requirement previously discussed.<sup>58</sup>

Today, AOST consists of a classroom-based session on the department's Use of Force Policy, defensive tactics, Simunitions/scenario training, and MILO<sup>59</sup> simulations.<sup>60</sup> The Use of Force Policy session is a partial fulfillment of the requirement that officers receive training on the policy twice per year.<sup>61</sup>

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52. LVMPD, "General Order 021-12," (2012).

53. G.P. Alpert, and R.G. Dunham, "Policy and Training Recommendations Related to Police Use of CEDs: Overview of Findings from a Comprehensive National Study on CED," *Police Quarterly* 13 (2010):235.

54. LVMPD, "5/108.9, Advanced Officer Skills Training," *LVMPD Policy Manual* (no date).

55. "Simunitions" refers to simulated ammunition, often plastic or rubber pellets.

56. CNA observations.

57. CNA interviews.

58. LVMPD, "General Order 021-12," (2012).

59. MILO is a training platform using a projection screen and interactive tools. MILO is simply the name the manufacturer has given the system; it is not an acronym.

60. CNA site visit and observation. July 17, 2012.

61. LVMPD, "5/108.14, Firearms Training," *LVMPD Policy Manual* (no date).

The defensive tactics portion of the course fulfills one of the officer's quarterly requirements for two hours of defensive tactics instruction. Therefore, two of the components of AOST are partial fulfillments of other requirements set forth in the department's policy manual.

A notable component of the department's AOST requirement is training through Simunitions/scenario and MILO training; this type of training has been found to be the most common and preferred method of delivering tactics and judgment training.<sup>62</sup> The role-playing aspect of Simunitions/scenario training is less common but is generally desirable except for resource constraints.<sup>63, 64</sup>

The Simunitions/scenario training places officers, in teams of two, in three distinct situations with training officers acting as real-life suspects, victims, or witnesses, in a realistic environment. Collectively, LVMPD's Simunitions training in 2012 covered legal and tactical issues. Officers were trained and tested in the following areas: reasonable suspicion and probable cause for arrest; pat-downs; de-escalation; less-lethal force; officer safety; and situational awareness.<sup>65</sup> The scenarios vary in length but are generally about 10 minutes long.<sup>66</sup> After each team of two goes through each of the three scenarios, they are debriefed by the training team on the purpose of the exercise, what they did right, what they could have done better, and what they did wrong.<sup>67</sup>

The MILO training consists of an additional three scenarios that play out on a large projection screen. The scenario is essentially a short movie with real-life police officers as the actors. The trainer can direct the scenario into as many as four different outcomes with the click of a mouse. For instance, the trainer can determine whether the subject on the screen is compliant or aggressive toward the officer. The officers watching are equipped with a simulated (i.e., fake, or plastic) firearm and ECD that interact with the scenario playing out on the screen. Officers are also expected to issue verbal commands and use communications as if they were in a real situation. Collectively, the 2012 MILO scenarios trained and assessed officers on verbal communications with the suspect; de-escalation; use of less-lethal force; and situational awareness.<sup>68, 69</sup> The MILO training session ends with a debriefing by the trainer on the purpose of the exercise; what officers did right, and what could be improved.

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62. G.B. Morrison, "Deadly Force Programs Among Larger U.S. Police Departments," *Police Quarterly* 9, no. 3 (2006): 331.

63. International Association of Chiefs of Police, *Emerging Use of Force Issues: Balancing Public and Officer Safety*, (Alexandria, VA: International Association of Chiefs of Police, 2012).

64. Police Executive Research Forum, *Review of Use of Force in the Albuquerque Police Department*, (Washington, D.C.: Police Executive Research Forum 2011).

65. CNA observations; LVMPD, *AOST Student Performance Assessment Form: Scenario* (no date).

66. CNA observations.

67. Ibid.

68. CNA observations.

69. LVMPD, *AOST Student Performance Assessment Form: MILO* (no date).



## Reality-based training (RBT)

In September 2011, LVMPD began a new supplemental training program known as “reality-based training” (RBT). The training is a semiannual (twice per year) requirement for all sworn personnel at the rank of sergeant and below. The program is similar to AOST, consisting of a classroom component and two Simunition scenarios. Each RBT module is approximately five hours long. This new program has significantly increased the amount of scenario training conducted at LVMPD. Additionally, the program uses empirical incident data to develop scenarios and identify tactical assessments that need to be included.

One distinguishing facet of RBT is that Simunition scenarios are conducted with squads of four officers who actually work together on the streets. Another differentiator is the isolation of sergeant training and officer training in RBT. Sergeants train with role players from the training bureau acting as their squad. Officers run through the scenario while their sergeant observes, rather than taking part in the scenario itself.<sup>70</sup> Sergeants also run through the scenario without their squads. LVMPD trainers have noted that by observing their squad (rather than participating in the exercise) with the training bureau, sergeants are in a better position to identify strengths and weaknesses within their squads.<sup>71</sup> Additionally, the role players assigned to the sergeant during their training intentionally make mistakes so that evaluators can assess the sergeant’s ability to command and control the situation and the squad.<sup>72</sup>

The second RBT module of 2012 covered a wide array of tactical issues in two distinct scenarios. These included: identifying the type of situation (e.g., barricade, active shooter, ambush); cover and concealment; less-lethal force; deadly force; radio communications; and contact and cover (i.e., coordination).<sup>73, 74, 75</sup> It’s important to note here that, as in AOST, not every scenario involves deadly force. This variation makes the training more realistic and presents a different mindset and range of tactical options to officers.<sup>76</sup>

At each scenario’s completion, the squad meets in a room for a debriefing with the trainers and their sergeant. They view a video recording of the scenario from multiple angles and discuss the strengths and weaknesses of their response.

The RBT program consists of some other noteworthy evaluative components. One is that the Critical Incident Review Team (CIRT) plays a role in developing the tactical assessments that should be a part of the scenarios. Further, these tactical issues are driven by CIRT OIS reviews. In this sense, the department has taken a major step in making this training program empirically based by proactively analyzing use of force incident data and incorporating findings into training operations. Common mistakes that have occurred during OISs are specifically addressed in the

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70. CNA observations.

71. CNA interviews.

72. Ibid.

73. LVMPD, *AOST/RBT Officer Performance Assessment: Ambush Scenario* (no date).

74. LVMPD, *AOST/RBT Officer Performance Assessment: Mentally Ill Subject with a Knife at a Bus Stop* (no date).

75. CNA observations.

76. Police Executive Research Forum, *Review of Use of Force in the Albuquerque Police Department*, (Washington, D.C.: Police Executive Research Forum, 2011).

RBT scenarios. For instance, the most common tactical errors in OISs over the past five years have involved radio communications (39 percent); coordination (31 percent); officer approach (29 percent); and taking cover (23 percent). These issues are addressed in the RBT assessment. Additionally, the RBT program systematically collects and analyzes performance assessments, identifying department-wide trends of how squads respond to the scenario and their performance of specific tactics.

## Use of force policy training

According to LVMPD policy and POST requirements, officers are typically trained on the Use of Force Policy twice a year. This training is completed as a component of other training, such as firearms qualifications or annual use of force simulation training.

However, LVMPD revised its Use of Force Policy in May 2012 and initiated a specialized training program to train its workforce on the new policy. The LVMPD leaders committed to train 2,700 sworn personnel in five weeks in order to expedite the issuance of the revised Use of Force Policy. This classroom training is delivered by two instructors for each class. Class sizes range from approximately 12 to 100 officers and civilian personnel. Instructors use an introductory video of the sheriff stating his personal commitment to the revised policy. This statement is followed by PowerPoint slides, which present material and are interspersed with four video-recorded interviews with officers who have been involved in OISs.

The training states the new policy; defines relevant definitions and terms; identifies the conditions in which an officer may reasonably use force and discusses the factors to consider; and details level of resistance, levels of control, and force options. It also addresses supervisory responsibility for de-escalation and the overall response to a potentially deadly encounter.<sup>77</sup>

Traditionally, LVMPD has evaluated its Use of Force Policy training by distributing a written exam to trainees and tracking the pass/fail rate. However, LVMPD is now using its internal web server to administer the post-training exam and is able to identify specific question/response trends. This will enable the department to improve and tailor future training according to its student evaluation data.

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77. LVMPD, "Standardized Lesson Plan: Use of Force Policy Revision," (2012).

## Findings and recommendations

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### **FINDING 6.1: Defensive tactics training in LVMPD lacks consistency in terms of quality and quantity throughout the department.**

Although much of defensive tactics training will fall at the lower end of the use of force model, it has been noted that improving this kind of training can reduce use of force problems overall, including problems concerning use of deadly force.<sup>78</sup> Interview participants throughout the department noted deficiencies in LVMPD's defensive tactics training. The foremost concern was that, although a standard manual is distributed to all defensive tactics instructors (DTI), defensive tactics training was not conducted in a uniform way, particularly when done away from LVMPD's training bureau. To paraphrase, pressure to "keep cops out on the street" and "get training done and out of the way" was commonly referenced by interview participants.<sup>79</sup>

Inconsistencies were most often observed when we asked about the length of quarterly defensive tactics training. Interview participants gave a range of responses, from 30 minutes to four hours, supporting claims that the training lacks uniformity. Additionally, our analysis of defensive tactics training shows that approximately 15 percent of officers required to receive eight hours of defensive tactics training annually fail to do so without a medical or other excuse.<sup>80</sup>

A lack of consistency in training was a common theme for many discussions we had with LVMPD personnel and some of our observations as well. This involved not only defensive tactics but also other training modules, such as AOST and Use of Force Policy training.

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### **RECOMMENDATION 6.1: LVMPD should exercise necessary oversight and control to ensure consistency through a policy of instructor audits.**

At the present time, LVMPD does not have a system in place to audit the instruction of training throughout the department. Rather, training materials are reviewed. The training bureau or another designated, qualified component of LVMPD should conduct audits of defensive tactics and all other classroom-based and scenario-based training, including AOST and RBT, throughout the department to ensure that the appropriate amount of time is devoted to those requirements and that the appropriate techniques are being taught by DTIs and other certified instructors.

This system of auditing should include any mandatory course taught by an instructor throughout the department, including specialized units. Trainers, assigned as auditors, should randomly select and attend scheduled defensive tactics training throughout the department. The audits should be unannounced. Audits should cover the content and the quality of defensive tactics instruction, as well as attendance and previous lessons to ensure that the department's defensive tactics manual is being followed.

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78. Police Executive Research Forum, *An Integrated Approach to De-Escalation and Minimizing Use of Force*, (Washington, D.C.: Police Executive Research Forum, 2012).

79. CNA interviews.

80. LVMPD UMLV training database.

**IMPLEMENTATION STEPS:**

1. Increase the number of trainers in the Training Bureau to provide sufficient staff for an auditing component. This staff should include:
  - a. Two trainers
  - b. One civilian analyst
2. Develop a process to assign trainers on a rotating basis to conduct unannounced audits of defensive tactics training.
3. Auditing should include the following:
  - a. Unannounced attendance at training
  - b. Review of attendance list
  - c. Review of lesson plan and attendance list for past sessions
4. Develop and provide an auditing checklist/form for auditors, to include:
  - a. Name of trainer
  - b. Topics covered
  - c. Length of training
  - d. Type of training (e.g., scenario-based, classroom)
  - e. Review of lesson plan for content
  - f. Handouts provided during training if applicable:
    - i. Handouts should be collected and reviewed by auditor to ensure that they are consistent with department policy and standards
  - g. Apparent receptiveness and attentiveness of attendees
  - h. Training attendance, including:
    - i. Number of attendees, ranks, assignments
    - ii. List of scheduled attendees
5. Auditors should identify absentees and whether their absence was excused and rescheduled.
6. Quarterly reports should be prepared that document a summary of audit results and any recommendations for improvement. The report should be distributed to all bureau/area commands.
7. An annual summary of audits should be produced and reported to executive/command staff.

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**FINDING 6.2: LVMPD is unable to determine whether officer training requirements are being properly monitored by the Bureau Training Coordinator program.**

The Bureau Training Coordinator program is the first and primary component of LVMPD that monitors and ensures the completion of training requirements throughout the department. Currently, LVMPD bureau commanders may appoint a bureau training coordinator to schedule and assist in monitoring the completion of POST and department-mandated training requirements.<sup>81</sup> There are currently 33 bureau training coordinators throughout LVMPD who serve this function in addition to their other duties as sworn officers. The bureau training coordinators are responsible for monitoring the completion of training requirements; yet, this program has not been assessed since its inception in December 2010. LVMPD policy delegates the task of auditing the program to the Quality Assurance Unit.<sup>82</sup>

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**RECOMMENDATION 6.2.1: LVMPD should follow existing policy and audit the Bureau Training Coordinator program to ensure that it is accurately monitoring and tracking completion of training requirements.**

Given the essential role that the bureau training coordinators play in ensuring compliance with training requirements, LVMPD should assess the program to ensure that it is meeting its expectations and showing results. If the audit of the program reveals any deficiencies, major or minor, LVMPD should take appropriate steps to address them. These steps could include changing reporting structures or personnel assignments, or making larger organizational changes, as determined by LVMPD and the results of the audit.

**IMPLEMENTATION STEPS:**

1. Design an auditing process for the program. The audit should include:
  - a. Interviews with training coordinators, line officers, and supervisors
  - b. Analysis of training compliance by area command/bureau
  - c. Review of monthly training reports and any other standardized reports that training coordinators are responsible for submitting to commanders
2. Produce a report on audit findings that highlights strengths and weaknesses and provides recommendations for improving the program.
3. Disseminate findings to executive staff, supervisors, training coordinators, and line officers.
4. Establish a process for changing the bureau training coordinator program as needed.
5. If the program is deemed insufficient, consider designing a new system for monitoring the completion of training requirements that includes dedicated personnel.

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81. LVMPD, "5/102.33, Bureau Training Coordinator," *LVMPD Policy Manual* (no date).

82. *Ibid.*

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**RECOMMENDATION 6.2.2:** LVMPD should update its training database to accurately reflect officer rank for each year. Additionally, LVMPD should update its archiving process to include this information for all future years.

LVMPD's University of Metro Las Vegas (UMLV) training database archives training hours for each officer in the department. However, it does not archive ranks of officers for each respective year. Because many requirements differ according to rank, this makes identifying training deficiencies and trends over time unnecessarily onerous. LVMPD's UMLV personnel should work with their IT department and the payroll department to update their current training archive and build-in a future data requirement to accurately reflect officer rank each year. This will better enable training staff and supervisors to identify trends and patterns of behavior with respect to meeting training requirements and provide a basis for early intervention when necessary.

**IMPLEMENTATION STEPS:**

1. Work with payroll to identify promotion years of all officers.
2. Use payroll information to update training archives, so that officer rank for each year is accurate.
3. Update internal system to capture officer rank at the current time when updating training completion.
4. Establish a policy to track when officers are promoted or have new assignments that will affect their training requirements.

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**FINDING 6.3:** LVMPD's Crisis Intervention Team recertification program does not contain sufficient frequency or number of hours.

Many CIT officers have gone as long as nine years without being recertified. Without recertification training, vital skills can deteriorate. LVMPD has recently established a recertification process.<sup>83</sup> According to LVMPD, the program will allow the department to train up to 400 officers per year.<sup>84</sup> Recertification will be done on a three-year basis and, as of now, classes are approximately four hours long.<sup>85</sup> The initiation of a recertification process is an important step toward improving LVMPD's CIT program. As new information, new science, and new practices emerge, recertification allows the department to be adaptive and keep officers' skills up to date.

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83. CNA interviews.

84. Ibid.

85. Ibid.

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**RECOMMENDATION 6.3:** LVMPD should update its training policies to reflect the CIT recertification requirement and increase its number of hours and frequency.

LVMPD should ensure that CIT recertification is institutionalized by updating its current policy to reflect this new requirement. Further, the department should consider increasing the frequency of recertification and/or the number of hours for recertification courses. The Houston Police Department, for example, has been identified as a CIT learning site by the Council of State Governments Justice Center and provides CIT recertification for all officers on a biennial basis (i.e., once every two years) with eight-hour courses.<sup>86</sup> LVMPD should also continue to work with mental health professionals and local hospitals to ensure that CIT training is relevant and grounded in science.

**IMPLEMENTATION STEPS:**

1. Identify the time and resources needed to modify the CIT recertification requirement to be longer and more frequent.
2. Review LVMPD CIT responses and reports in order to identify training needs and update training as necessary.
3. Consider conducting site visits to other agencies that have well-established and dynamic mental health programs in order to learn about best practices and incorporate those into LVMPD training.

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**FINDING 6.4:** The LVMPD policy manual has not been updated to reflect current AOST requirements.

LVMPD's policy on AOST is outdated. In its current form, it includes two requirements that are no longer a part of AOST: one hour of quarterly firearms qualification; and two hours of ECD recertification (to satisfy one quarterly defensive tactics requirement for the year). AOST did not allow sufficient time for firearms qualification and was, therefore, abandoned as an add-on to that curriculum. The need for ECD re-certification has been overridden by the department's new specialized, four-hour, ECD recertification course, which is conducted outside of AOST.

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**RECOMMENDATION 6.4:** LVMPD should update its policy to reflect its actual Advanced Officer Skills Training (AOST) program.

LVMPD should update the AOST portion of its policy manual. The ECD requirement (as part of defensive tactics) should be changed to say that one quarterly defensive tactics requirement will be satisfied as part of AOST. The firearms qualification portion of the AOST policy should be removed in its entirety, as training staff have recognized that AOST does not allow for a sufficient amount of time to qualify, assess, and redress any deficiencies found during firearms qualification.

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86. Police Executive Research Forum, *An Integrated Approach to De-Escalation and Minimizing Use of Force*, (Washington, D.C.: Police Executive Research Forum, 2012).

## IMPLEMENTATION STEPS:

1. Review current practice of AOST and update policy manual to describe it accurately.
2. Distribute policy changes and notify personnel through the appropriate LVMPD distribution process, roll call announcements, bulletins, and the training coordinator's scheduling procedures.

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### **FINDING 6.5: LVMPD de-escalation training is not a requirement and does not include an evaluation component.**

De-escalation techniques have been known to help reduce the need for use of force.<sup>87</sup> However, interpersonal communication proficiency and de-escalation have not been a part of LVMPD's organizational culture in the past.<sup>88</sup> Many interviewees expressed dissatisfaction with the amount of de-escalation training in the department.

We found that during the period of study (2007–2011), officers made numerous tactical errors concerning de-escalation in OIS incidents. Verbal commands were insufficient in approximately 15 percent (n = 13) of the cases. However, research has shown that verbal commands that are explicit, clear, and direct, result in greater compliance in both violent and non-violent encounters.<sup>89</sup> When an officer's approach was found to be flawed, it was because the officer(s) failed to slow the momentum of the incident approximately 21 percent (n = 18) of the time.

Although voluntary courses in topics such as "verbal judo" and CIT have been offered by the department for some time, LVMPD has recently emphasized de-escalation tactics in some of its mandatory training modules: AOST, Use of Force Policy training, and RBT. For example, one out of three AOST Simunition scenarios from 2012 includes a de-escalation component. Two out of three AOST MILO scenarios include a de-escalation component. One of the two RBT scenarios from the second half of 2012 also includes a de-escalation component.

However, AOST Simunition and MILO performance assessments do not sufficiently account for de-escalation tactics. For instance, the performance assessment form for the AOST Simunition scenario that includes a de-escalation component only asks whether the officer used proper radio traffic, communicated with other officers, and appropriately deployed less-lethal tools.<sup>90</sup> It does not ask about verbal attempts to de-escalate.

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87. J.J. Fyfe, "Training to Reduce Police–Civilian Violence," in *And Justice for All: Understanding and Controlling Police Abuse of Force*, ed. W. Geller and H. Toch (Washington, D.C.: Police Executive Research Forum, 1995), 163–75.

88. CNA interviews.

89. E. Schwarzkopf, D. Houlihan, K. Kolb, W. Lewinski, J. Buchanan, and A. Christensen, "Command Types Used in Police Encounters," *Law Enforcement Executive Forum* 8, no. 2 (2008): 99–114.

90. LVMPD, *AOST Student Performance Assessment Form: AOST* (no date).



Similarly, performance assessment forms for MILO scenarios only ask whether officers used “good verbal communication.”<sup>91</sup> Although this may be intended to gauge de-escalation, it is too vague and subject to interpretation. Good verbal communication could mean issuing clear, direct commands. However, it may not be evidence that the trainee attempted to de-escalate the situation. In contrast, RBT performance assessments include more explicit items on de-escalation, such as whether students were able to “recognize the severity of the incident” or “slow down the momentum.”<sup>92</sup>

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**RECOMMENDATION 6.5.1: LVMPD should establish an annual requirement for officers at the rank of sergeant and below to undergo a minimum number of hours of de-escalation training and formalize assessments of de-escalation tactics in AOST and RBT.**

Given the prevalence of de-escalation tactical errors in OISs in recent years, the history and culture of inattention to the topic, and the department’s recent commitments to addressing de-escalation in earnest, we recommend that the department institutionalize these efforts by establishing an annual requirement for de-escalation training. The requirement should include effective communication and verbal commands.

LVMPD should develop scenario- and classroom-based curriculum for de-escalation based on real-life incidents. Like other requirements in the department, the de-escalation training requirement could be incorporated into other training, such as AOST, RBT, Use of Force Policy, and defensive tactics. In addition to critical incidents, de-escalation training should be incorporated into scenarios for simple non-compliance incidents (i.e., passive resistance) and incidents where no police action is necessary or warranted, where it has been noted that de-escalation and social skills may be particularly challenging.<sup>93</sup>

**IMPLEMENTATION STEPS:**

1. Review current de-escalation training provided in various courses, including the number of combined hours currently provided.
2. Determine which courses could be revised or extended to include increased and improved de-escalation training.
3. Update lesson plans to include actual training of de-escalation techniques, not just mention of them.
4. Areas to be covered consistently and uniformly include:
  - a. Effective communications
  - b. Verbal commands
  - c. Communications during passive resistance
  - d. De-escalation techniques
  - e. Risk/threat mitigation techniques

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91. LVMPD, *AOST Student Performance Assessment Form: MILO* (no date).

92. LVMPD, *AOST/RBT Officer Performance Assessment: Mentally Ill Subject with a Knife at a Bus Stop* (no date).

93. Police Executive Research Forum, *An Integrated Approach to De-Escalation and Minimizing Use of Force*, (Washington, D.C.: Police Executive Research Forum, 2012).

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**RECOMMENDATION 6.5.2:** LVMPD should devote one quarter of its defensive tactics training to de-escalation.

LVMPD previously devoted one quarter of its defensive tactics training to the use of the ECD. That requirement was overridden by a new, specialized ECD recertification course. LVMPD should fill that quarter with training on de-escalation tactics. The Training Bureau and defensive tactic instructors should convene to develop a defensive tactics de-escalation curriculum that fills two hours of LVMPD annual requirements. The curriculum should entail communication skills, recognition of when/how to “slow down the action,” and use of effective verbal commands.

**IMPLEMENTATION STEPS:**

1. Update the defensive tactics training manual to reflect the new de-escalation requirement.
2. Update the policy manual to include the new de-escalation component of annual defensive tactics training requirement.

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**FINDING 6.6:** LVMPD’s new Reality-Based Training program is essential to the department’s efforts to continue to improve officers’ tactics and prepare them for various real-life encounters. However, scheduling conflicts have hampered the program’s full implementation.

RBT essentially doubles the amount of scenario training that LVMPD officers receive in a year. The department implemented this new training program as a result of increasing OISs in 2010 and the apparent lack of tactical discipline in many cases, as identified by CIRT. The program is resource intensive and was implemented without first conducting a manpower study. Current squad schedules are not conducive to the program’s semi-annual requirement. Because RBT requires that officers train as a squad, scheduling conflicts arise. Squads are not available frequently enough for RBT to be completed two times a year. This is because RBT training takes place on squad training days, which are generally when squads overlap (i.e., there are two squads on the street in one area command). However, there are not enough overlap days to cover all squads twice per year. As a result, RBT training is taking approximately 9-10 months to complete each module, which means the annual requirement will take between 18 and 20 months to complete.<sup>94</sup>

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**RECOMMENDATION 6.6:** LVMPD should proceed with the current schedule of RBT and conduct a manpower study in order to ensure that it can accommodate the completion of twice yearly RBT.

LVMPD should make RBT work as a semi-annual requirement. To do so, the department will need to conduct a study that examines its squad schedules, staffing, and time needed for RBT to be conducted twice per year for every squad in the department. The study’s goals should be to create efficiencies in the RBT program and create options for ensuring that RBT is a semi-annual requirement, as it is intended to be.

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94. CNA interviews.

**IMPLEMENTATION STEPS:**

1. Convene an internal group of analysts, trainers, and command staff, including management analysts to initiate the study and outline its purpose.
2. Define the manpower problem and the solution desired.
3. The manpower study should
  - a. determine the number of RBT trainers needed to maintain the program's semiannual requirement
  - b. determine changes in scheduling that would need to occur
  - c. provide a range of options for meeting the RBT semiannual goal

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**FINDING 6.7:** The evaluation components of LVMPD's training programs are inadequate. They do not focus on department-wide trends, which could highlight problem areas that need to be addressed more thoroughly.

It is noteworthy that LVMPD has made substantial changes to its Use of Force Policy revision training, as we detailed in the previous section of this report. Additionally, the RBT program has some laudable features in terms of data collection and evaluation. However, rigorous, systematic evaluations of performance and knowledge are still generally lacking throughout LVMPD's training programs.

We observed this in various training modules throughout the department. In instances where officers are required to complete an exam, it is typically paper based and scored in the classroom by other officers in the class, essentially relying on an honor system. The goal of the exams is to ensure that every officer passes, so that he or she can claim proficiency and be up to date on requirements. Once the exams are completed, officers are scored on a simple pass/fail basis and the exams are filed away into their records.

Similarly, tactical training (e.g., defensive tactics, or AOST) evaluations are typically done in real time and the records of officers are filed away and not used to identify any trends in performance, across either the department or an officer's career. Although the department's approach to collecting and evaluating training data is convenient and efficient, it does not serve the department as well as it could.

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**RECOMMENDATION 6.7:** LVMPD should develop a greater data collection and evaluation capacity for all training conducted throughout the department and should use that data to proactively address any deficiencies.

Trainee evaluation data should be collected in a centralized database that enables training staff and supervisors to identify performance trends. Classroom-based trainee evaluations should be recorded not only on a pass/fail basis, but on a more granular question-level basis as well. Additionally, when possible, training evaluators should incorporate Likert-type measures (i.e., scores of 1–5 rather than yes/no) into their tactical evaluations to allow for distinctions in quality, as well as noting whether a specific task was completed.

The training database should include each officer's name and identification number; *all* completed training; rank at the time of the training; score on each training module completed; and instructor comments, if applicable. LVMPD should incorporate these data into its early intervention system. Additionally, these data should be used to generate quarterly reports for all supervisors, OIO, and ODB. The report should highlight trends in training performance and can be used to reemphasize important concepts or initiate ad-hoc training as needed. Additionally, individual officers may be identified as needing remedial training and counseling as a result of consistently low scores.

The Training Bureau does not currently have the expertise or manpower to complete this function.<sup>95</sup> To address this limitation, LVMPD should consider assigning analytic support to the Training Bureau.

### **IMPLEMENTATION STEPS:**

1. Determine IT needs for centralized training database.
2. Review and revise all training evaluation forms as necessary to capture data described above.
3. Assign staff as needed for management, analysis, and reporting functions with respect to training.
4. Update the policy manual as necessary to formalize the new data collection process, analysis, and reporting functions.

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### **FINDING 6.8: Some LVMPD instructors did not express support for portions of the Use of Force Policy reforms during training.**

Officers need to understand the potential ramifications of their actions. As an organization, LVMPD has an obligation to communicate its expectations and the penalties for failing to meet professional standards, including the impact on the officers themselves (e.g., loss of job or income) and the department as a whole (e.g., lawsuits and financial impact). But in our observation of five Use of Force Policy revision courses, instructors focused almost exclusively on these negative outcomes and neglected requirements to uphold the values of the department and represent excellence in policing.

For instance, LVMPD's Use of Force Policy includes a "duty to intervene," which states, "Any officer present and observing another officer using force that is clearly beyond that which is objectively reasonable under the circumstances shall, when in a position to do so, safely intercede to prevent the use of such excessive force. Officers shall promptly report these observations to a supervisor."<sup>96</sup> In the training that we observed, the discussion of this topic was accompanied by videos intended to demonstrate when officers should have intervened but did not.<sup>97</sup> However, rather than express their disapproval, and, by extension, the department's disapproval, of the actions shown, instructors only communicated the legal consequences and the fact that the officers might lose their jobs.

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95. CNA interviews.

96. LVMPD, "General Order 021-12," (2012).

97. CNA observations.

Most troubling is the fact that, on some occasions, LVMPD instructors expressed outright disapproval of some components of the new policy to trainees during class. Police leaders have noted that this can be particularly damaging to the successful implementation of a new policy or training program.<sup>98</sup>

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**RECOMMENDATION 6.8:** Instructors should express support for new policies. When illustrating policy violations, they should take the opportunity to explain that they are not only potentially illegal but that they do not represent the best in policing or reflect the values of the police department. This should be ensured through instructor training and audits of instruction conducted throughout the department.

Instructors should be trained to embody and embrace the policies and practices of the department. Further, LVMPD should establish a schedule of audits of in-house instructors to be conducted throughout the year. Although LVMPD audits course material and requirements on a semi-regular basis, it has not established a system to audit the instruction of training throughout the department. The audits should cover the content of the training as well as the quality of its delivery. Audits should be conducted randomly and without prior notice.

**IMPLEMENTATION STEPS:**

1. Ensure instructor support through instructor training and audits. Audit should include:
  - a. Evaluation of the professionalism, behavior, and attitude of the in-house instructor
  - b. Evaluation of the perceived receptiveness, attitude, behavior, and response of the trainees
2. OIO or training bureau supervisors should use audits to make recommendations for any changes, additional training, or corrective action based on the audits.
3. Consideration should be given to removing in-house instructors from training assignments who consistently demonstrate a disdain or lack of support for policies and procedures of the LVMPD.
4. Engage police associations, human resources, command staff, and legal counsel to develop a fair but effective process to correct behavior or remove in-house instructors if they are deemed unprofessional or inappropriate.

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**FINDING 6.9:** Actual LVMPD radios are seldom used in LVMPD scenario-based training. However, in our review of OIS incidents, the most frequent tactical error involved radio communications.

In our observations of LVMPD training, the officers used actual LVMPD radios in just two out of eight scenarios (three AOST Simunition scenarios, three AOST MILO scenarios, and two RBT Simunitions scenarios). This is despite the fact that radio communications are the number one tactical deficiency in LVMPD OIS incidents, as shown by our analysis. Forty percent of OIS incidents involved some sort of breakdown in radio discipline, mostly as the result of officers not updating dispatch of their location or communicating with other officers who are en route or on-scene

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98. Police Executive Research Forum, *An Integrated Approach to De-Escalation and Minimizing Use of Force*. (Washington, D.C.: Police Executive Research Forum, 2012).

when they should have.<sup>99</sup> Lack of radio discipline makes it difficult for incident commanders and patrol officers to coordinate tactics and assign tasks. Such strategic deployment of resources is a matter of public safety and officer safety.

Interviewees frequently commented that the department's radios were a problem as a result of technical issues (i.e., the radios were not functioning properly). We directly observed this issue in ride-alongs with LVMPD patrol units. This issue, however, does not negate the importance of radio discipline.

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**RECOMMENDATION 6.9:** In all scenario-based training, trainees should be using actual LVMPD radios to enhance the experience and make it as realistic as possible.

The more realistic training is, the more prepared officers will be for duty.<sup>100</sup> Given the prevalence of radio discipline issues exhibited in OIS incidents, it is imperative that LVMPD training incorporate actual LVMPD radios and radio traffic into all of its scenarios. This includes AOST Simulations, MILO, and RBT.

Incidentally, performance assessments for these training modules should also include radio communications, including updating dispatch, requesting backup, and communicating with other officers on scene and en route.

**IMPLEMENTATION STEPS:**

1. Develop a procedure for regularly using live communications and radio use during scenario and interactive training.
2. Procedure should include the following:
  - a. Reserving tactical frequency for the anticipated training period
  - b. Notifying dispatch that training is being conducted
  - c. Assigning a dispatcher to perform the function of the on-duty dispatcher for the training session
3. Direct trainees to include radio communications in their response to scenarios as if it were a real-world event.
4. Include the use of a radio in trainee debriefing.
5. Modify training as needed based on instructor observations and lessons learned from prior training sessions.

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99. Just 2 out of 35 OIS incidents (~ 5 percent) that had communications breakdowns were the result of equipment malfunctions.

100. Police Executive Research Forum, *Review of Use of Force in the Albuquerque Police Department*. (Washington, D.C.: Police Executive Research Forum, 2012).

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**FINDING 6.10:** LVMPD's evaluation of the most recent Use of Force Policy training suggests that officers have the most trouble comprehending policy in the context of a written scenario.

After the department's recent policy training, 2,404 officers answered 13 Use of Force Policy questions to gauge their understanding of the policy. For 11 out of the 13 questions, approximately 99 percent of officers answered correctly. However, the two questions that presented scenarios to the officers yielded a much lower rate of accurate responses. Approximately 20 percent of officers were unable to accurately describe a subject's level of resistance and the appropriate level of control to use. Approximately 12 percent of officers were unable to accurately identify the basis for an authorized use of ECD on a fleeing suspect.

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**RECOMMENDATION 6.10:** LVMPD should take the appropriate steps to understand whether the failed test questions were problematic due to the clarity of the question or to officers' lack of comprehension.

LVMPD should hold focus groups with officers who answered the questions correctly and those who answered incorrectly, in order to discern the relevant causes of incorrect answers. The focus group facilitator should seek to understand whether the questions were worded clearly, whether the officers had received the information needed during training, and whether officers simply had trouble with any concepts or the way they should be applied in scenarios. LVMPD should also take this opportunity to retrain the officers in the new ECD policy and the force model.

**IMPLEMENTATION STEPS:**

1. Identify officers who failed to correctly answer scenario-based questions on the Use of Force Policy exam.
2. Select a facilitator for focus groups.
3. Schedule a series of focus groups with randomly selected officers:
  - a. Focus groups should include no more than 10 participants and no fewer than seven.
  - b. For each of the two scenario-based questions, hold at least two focus groups of officers who answered each question incorrectly (for a total of four focus groups).
  - c. For each of the two scenario-based questions, hold one focus group of officers who answered the questions correctly (for a total of two focus groups).
4. If it is learned through the focus groups that officers had trouble with the concepts involved, issue bulletins, memos, and other appropriate means of communication throughout the department reinforcing the concepts and their proper application.
5. If it is learned through the focus groups that the test questions and answers were insufficient or unclear in some way, revise the test as needed.

## Chapter 7: Use of Force Investigation and Documentation

This chapter documents our review of LVMPD’s internal accountability system for investigating and documenting use of force. First, we review LVMPD’s investigative processes in criminal investigations of its OISs. We then review LVMPD’s current processes for conducting administrative investigations of OISs. Finally, we also review LVMPD’s current Use of Force Review Board process. These steps will give the reader a general overview of the processes that LVMPD uses to investigate and document use of force. After we give background information on each of the three internal accountability systems, we present our findings and recommendations.

### Force investigation team

Police officers must be accountable for the decision and authority to use deadly force. This responsibility is embedded in the culture of service to the public. When an officer takes an oath and is wearing a badge, he or she is responsible for abiding by the ethical and professional standards required. Officers’ duties include protecting and ensuring the safety of their communities, often in the face of danger and at great risk to their own lives. Their demonstration of the ability and will to do so is important to ensuring public trust, transparency, and police accountability. The IACP provides the following as a recommended statement of commitment to ethical behavior: “On my honor, I will never betray my badge, my integrity, my character, or the public trust. I will always have the courage to hold myself and others accountable for our actions.”<sup>101</sup>

Officers are often confronted by decisions, such as whether to use deadly force, that affect their lives and the lives of others. It is up to the leaders and executive command to ensure that the training and policies provided to officers will guide them to conduct themselves in a professional and ethical manner and to provide full reports on all the facts and circumstances relevant to the actual decision to use deadly force.

Legal and policy reforms over the past 45 years—such as *Garrity v. New Jersey* (1967), *Tennessee v. Garner* (1985), and the 1994 Violent Crime Control and Law Enforcement Act—have enabled police departments to push for more accurate and thorough investigations on a police officer’s use of deadly force. Traditionally, police agencies assign homicide investigators to all OISs resulting in the death or serious injury of a suspect.<sup>102</sup> Some agencies assign specially trained investigators to OIS incidents.

In an effort to mitigate the complexities that arise when conducting an investigation of an OIS, LVMPD established a Force Investigation Team (FIT) in October 2010. The FIT is responsible for responding and conducting a criminal investigation related to an officer’s use of deadly force and potential crimes committed against the officer during the incident.<sup>103</sup>

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101. International Association of Chiefs of Police, “What is the Law Enforcement Oath of Honor?” (Alexandria, VA: International Association of Chiefs of Police, no date), [www.theiacp.org/PoliceServices/ProfessionalAssistance/Ethics/WhatistheLawEnforcementOathofHonor/tabid/150/Default.aspx](http://www.theiacp.org/PoliceServices/ProfessionalAssistance/Ethics/WhatistheLawEnforcementOathofHonor/tabid/150/Default.aspx).

102. Police Assessment Resource Center, *The Portland Police Bureau: Officer-Involved Shootings and In-Custody Deaths*, (Los Angeles, CA: Police Assessment Resource Center, 2003).

103. LVMPD. *Force Investigation Team Manual* (no date).



LVMPD's FIT is currently overseen by the Homicide and Robbery Division. LVMPD's vision of FIT and its objectives for the team have changed since its establishment in late 2010, as a result of shortages in personnel and increases in caseloads.<sup>104</sup> Initially, the LVMPD designated 14 officers to work solely on OIS investigations. They were divided into two FITs, each with seven personnel (six detectives and one sergeant).<sup>105</sup> Although this effort was a clear indication of progress in LVMPD's attempt to ensure complete, accurate, and thorough investigations of OISs, this model was easily affected by manpower issues.<sup>106</sup> The designation of FIT officers created shortages of personnel within the Homicide and Robbery Division, and the FIT officers themselves were overburdened by having only two teams. The result was that neither the personnel on FIT nor the others in the division could effectively and thoroughly investigate all of their cases.

In an effort to address the shortages in personnel and budgets, LVMPD has reverted to its prior model that assigns *all* homicide detectives to work on FIT investigations on a rotating basis. Although homicide detectives now have dual responsibilities, they make FIT investigations a priority.<sup>107</sup>

## Critical incident review team

In January 2007, LVMPD established an internal, expert panel, known as the Critical Incident Review Panel (CIRP), to review all instances of deadly force. This panel was established with the intent to improve training and policy in LVMPD through lessons learned from critical incidents.<sup>108</sup> CIRP started as a panel of three LVMPD commissioned personnel who would review a case after all other reviews (i.e., Coroner's Inquest, Homicide, and UoFRB) had been completed. CIRP was limited in that it would not directly interview the officer(s) involved.

Over 3.5 years, the CIRP process evolved into a more proactive team, known as the Critical Incident Review Team (CIRT). The CIRT review process was established in July 2010. CIRT has many of the same goals as its predecessor. Its strategy is to enhance training, policies, and procedures, and to educate the department through administrative investigations of critical incidents, including OISs, vehicle collisions involving LVMPD, any discharge of a firearm in the field, in-custody deaths, serious officer injuries and deaths, and any other high-risk incident at the request of the sheriff.<sup>109</sup> To implement this strategy, CIRT has a much broader reach and is far more proactive than its predecessor. CIRT functions are described in more detail in the following sections.

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104. CNA interviews.

105. *Ibid.*

106. *Ibid.*

107. *Ibid.*

108. LVMPD, "Critical Incident Review Panel" [administrative notice], Directive No. AN-08-07 (2007).

109. LVMPD, *Critical Incident Review Team Section Manual* (2012).

## *On scene*

When an OIS occurs, CIRT is one of the many LVMPD components to respond to the scene. Upon arrival, CIRT is briefed by the incident commander on the facts and circumstances of the incident and the current status of the scene. After the crime scene has been preserved and walked through by the FIT and Crime Scene Investigation (CSI) team, CIRT conducts its own walk-through and may direct crime scene analysts to take additional photographs for its review.<sup>110</sup> If the involved officers do not give interviews to FIT, CIRT gives those officers 48-hour notification of an employee administrative investigation, meaning that CIRT may contact the officer 48 hours after the incident to conduct an interview.<sup>111</sup>

## *CIRT administrative investigation*

To conduct its administrative review, CIRT uses the FIT investigation file, including any voluntary interviews. CIRT may also compel officer interviews, as participating in administrative investigations is a term of employment.<sup>112</sup> Within 48 hours after the incident, CIRT issues an awareness report to the LVMPD workforce, which gives a general, factual summary of the incident.

About two weeks into the CIRT investigation, CIRT investigators give a critical incident internal presentation to the Organizational Development Bureau (ODB), where training and tactical issues are discussed, concerning both the department as a whole and the individual officers involved.<sup>113</sup> If any issues or concerns are highlighted in this meeting, CIRT and ODB develop a plan for remedial training for the involved officer and work on implementing it.

CIRT uses its investigation, and the actions taken as a result of the ODB briefing, to compile two products that are integral to the department's administrative review: a CIRT administrative report, and a presentation before the UoFRB. The report details the incident, persons involved, chronology, and investigation, and provides an analysis of decision making, tactics, use of force, supervision, training, and policy. Recommendations are made that address both the department's training and policy and the individual officer's performance. The administrative report is the basis for CIRT's presentation before the UoFRB, thereby making it the lynchpin for the UoFRB.

## *Other functions*

In addition to conducting administrative investigations, CIRT has an analytic function to inform other LVMPD components. For example, CIRT works with the training bureau to incorporate OIS trends into its modules. Specifically, it gives quarterly updates to the Firearms Training and Tactics Unit (FTTU) with statistics on the characteristics of OISs.<sup>114</sup> CIRT has also played an integral role in the development of the department's annual training scenarios in AOST and RBT.<sup>115</sup> Most recently, CIRT has produced an annual review of OISs for public dissemination, in an effort to inform the public of the facts and circumstances surrounding OISs.<sup>116</sup>

110. *Ibid.*

111. *Ibid.*

112. *Ibid.*

113. *Ibid.*

114. *Ibid.*

115. CNA interviews.

116. LVMPD, *Deadly Force Statistical Analysis, 2010–2011* (2012).

CIRT comprises nine staff members: a lieutenant, a sergeant, four detectives, and three administrative personnel. It has recently come under the umbrella of the newly developed Office of Internal Oversight (OIO). LVMPD established OIO in February 2012; it reports directly to the sheriff on issues of use of deadly force in the department.

CIRT detectives are required to undergo 48 hours of training, which covers the CIRT's mission, investigative techniques, and the UoFRB.<sup>117</sup> Additionally, CIRT detectives are encouraged to attend other voluntary courses related to deadly-force case studies and investigative techniques.

## Use of force review board

LVMPD's UoFRB was born out of controversy. On July 31, 1990, three plainclothes officers entered the motel room of Charles Bush, unannounced and without a warrant. In the ensuing fight, Charles Bush was choked to death.<sup>118</sup> The subsequent acquittal of the involved officers sparked outrage in the community, prompting then-Sheriff John Moran to create an internal review process for OISs. Thus, the UoFRB was established, with the expressed purpose of examining the actions of all officers involved in all shootings in light of LVMPD standard operating procedures, training, and supervision.

It is important to note here that the UoFRB is an administrative hearing. Since its establishment, LVMPD's UoFRB has convened for any incident in which an officer has discharged his or her weapon or taken any action that could have or in fact resulted in death, excluding traffic accidents. According to LVMPD's Policy Manual, incidents which may be examined by the UoFRB include:

1. Incidents when a person is seriously injured or killed by a department member using any type of force, except traffic accidents.
2. Actions by a member that could have resulted in death or injury.
3. Deliberate shootings by a member at another human being, regardless of injury or damage.

The composition of the board has changed since its inception. Today, the board is composed of a mix of citizens and department personnel. The chairperson is a non-voting member and is appointed by the sheriff from the ranks of assistant sheriffs. Voting members include one member of the department with the rank of captain or above; the commander of LVMPD's Organizational Development Bureau; one peer member who has the same rank as the involved officer(s); and four resident citizens.

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117. LVMPD, "Critical Incident Review Team (CIRT) Investigator's Course," *LVMPD Standardized Lesson Plan* (no date).

118. A. Maimon, L. Mower, and B. Hayes, "Deadly Force: When Las Vegas Police Shoot, and Kill," *Las Vegas Review-Journal* (2011).

Peer members serve on a voluntary basis for a period of three years. For each case, a peer member is randomly selected using a computerized process. Citizen members are self-nominated to the department's Fiscal Affairs Committee, which, in turn, appoints members for a term of two years, for a period not to exceed two consecutive terms. Citizen members must complete orientation/ indoctrination training and stay current with department rules and regulations through additional training, as necessary. In sum, there are seven voting members: four citizens and three LVMPD personnel, which is an uncommon asymmetry in favor of citizen members. In addition to the board members, also attending the hearing are the involved officer, any witness officers, their supervisors, and a police association representative.

The practice of reviewing use of force incidents in a formalized manner such as a use of force board has been advocated as a promising practice for promoting police integrity and improving police operations.<sup>119, 120, 121</sup> However, little is known about the effectiveness of these boards or standards for their practices and composition. Our review of the research literature found zero evaluations of such police department functions.

### *The UoFRB process*

#### **Prior to the UoFRB**

Prior to holding a UoFRB, LVMPD provides and encourages each board member to review the FIT Officer's Report, CIRT Administrative Report, and member statements provided to CIRT.<sup>122</sup> UoFRBs are typically held about eight weeks after an incident, providing there are not contingencies in the investigations.

Based on the investigation conducted by the LVMPD Division's FIT, CIRT, and compelled interviews with the CIRT as stipulated under *Garrity*, CIRT completes an administrative and tactical review that is the basis for the presentation made by the CIRT primary case investigator.

If CIRT identifies a training deficiency during its investigation and review, this information is forwarded to the OIO, who then facilitates the completion of training, of the officer involved, prior to the UoFRB. Any training provided is documented in OIO's Informal Training Accountability Protocol (ITAP) Matrix, which is a spreadsheet that tracks the completion of UoFRB recommendations.

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119. U.S. Department of Justice, *Principles for Promoting Police Integrity: Examples of Promising Police Practices and Policies*, (Washington, D.C.: U.S. Department of Justice, 2001).

120. Independent Review Board, *The Baltimore Police Department: Police-Involved Shooting of January 9, 2011*, (Baltimore, MD: Independent Review Board, 2011).

121. G. Fachner, J.K. Stewart, and D.R. King, *Pairing After Actions: Policy Analysis and Incident Reconstruction in the Wake of a Critical Police Incident*, (Alexandria, VA: CNA, 2012).

122. LVMPD, *Critical Incident Review Team Section Manual* (2012).

## The UoFRB

Although the board is overseen by the chairman, who is also an assistant sheriff, the primary case investigator presents the incident facts and other pertinent information at the hearing.<sup>123</sup> The primary case investigator is currently and purposely filled by a detective on the CIRT. The CIRT primary case investigator makes his or her presentation before the entire UoFRB. In our direct observation of six UoFRBs, this presentation included the following specific elements:<sup>124</sup>

- Brief overview of the *Graham v. Connor* three-prong test
- A description of the location
- Chronology of actions leading up to the shooting incident
- Graphic simulation of the incident or video footage if available
- Portion of the radio transmissions from incident
- Officer statement
- Portion of the recording of officer interview
- Portion of the suspect's statement (if suspect survived the incident)
- Suspect identity and criminal history (if adult)
- Photos of the officer(s)
- Crime scene photos

The primary case investigator's presentation is followed by questions from the entire board—citizens and department members. These are mostly questions for clarification. After all the members have asked their questions, the board dismisses everyone in the room and convenes to make a determination.

The UoFRB voting members evaluate administrative issues, tactics, decision making, training recommendations, and departmental policy and practice. Until recently, the determination of the UoFRB members was limited to "Justified," "Unjustified," and "Justified with training violations."

In an effort to address community concerns that LVMPD was not holding its police officers involved in shootings accountable, the department recently revised its determinations to the following:<sup>125</sup>

- **Administrative approval:** No recommendations. Objectively reasonable force was used under the circumstances based on the information available to the officer at the time. This finding acknowledges that the use of force was justified and within LVMPD policy. There are no concerns surrounding the tactics employed, and there are no policy violations including those not relating to the application of force.
- **Tactics/Decision making:** This finding considers that the tactics and/or decision making employed were less than satisfactory. Specifically designed training will be prescribed to address deficiencies.

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123. As an assistant sheriff, he/she has direct communication with the sheriff and holds authority in ensuring that the recommendations and/or disciplinary action provided by the board and approved by the sheriff are followed through.

124. CNA observations.

125. CNA observations.

- **Policy violation not directly related to use of force:** This finding covers a range of policy violations including but not limited to failure to qualify with a firearm, use of unauthorized ammunition, failure to carry required equipment, etc. A policy violation was identified but was not connected to the use of force.
- **Policy/training failure:** An outcome was undesirable but did not stem from a violation of policy or failure to follow current training protocols. An LVMPD policy and/or specific training protocol is inadequate, ineffective, or deficient; the officer followed existing policy and/or training or there is no existing policy and/or training protocol that addresses the action taken or performance demonstrated. This finding reflects global policy or training deficiencies.
- **Administrative disapproval:** The UoFRB has concluded through this finding that the force used or action taken was not justified under the circumstances and violated LVMPD policy. This outcome is reserved for the most serious failures in adherence to policy, decision-making, and/or performance.

These new determinations broaden the scope of the findings beyond just what happened at the moment when an officer fired his/her weapon. Members now can review an officer's actions prior to the use of deadly force.

Once all members have submitted their votes, the board provides a determination and finding. After the determinations and findings have been announced, the officer involved in the shooting then meets, in private, with the assistant sheriff, the deputy chief of patrol, and the head of OIO, to review the determination and next steps.

## Post UoFRB

After the UoFRB, the deputy chief of patrol, in consultation with the chairman, produces a written document of the board's recommendations. This document is then sent to the officer's bureau commander. The bureau commander acknowledges receipt of the recommendation documentation, and a copy is provided to the OIO. It then becomes the responsibility of the bureau commander to facilitate the fulfillment of the UoFRB recommendations (OIO can assist if needed). Once the UoFRB's recommendations have been fulfilled, the officer's bureau commander notifies the deputy chief of patrol and provides details of fulfillment (e.g., dates, descriptions of training completed, comments from trainers, and discipline). This information is then forwarded to the OIO.

While the findings and recommendations are being carried out, the OIO produces a summary report, to be released to the public. This report provides a synopsis of the incident, the outcomes of the internal review, a summary of the FIT and DA's investigation, and the conclusions reached by the LVMPD's Use of Force Review Board.

## Findings and recommendations

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**FINDING 7.1:** LVMPD stopped the FIT model of one squad handling all officer-involved shootings, returning to a process of all homicide squads handling the investigations on a rotation basis.

LVMPD developed a Force Investigation Team (FIT) model in late 2010. But in April 2012, citing manpower issues, the Robbery and Homicide Division stopped the FIT model of one squad handling all OISs, returning to a process of all homicide squads handling the investigations on a rotating basis. LVMPD's FIT remains in name only (i.e., the department refers to OIS investigations as FIT investigations; however, there is no team per se). The manual for conducting these investigations does not formally establish the standards and specialized training required to be part of FIT.<sup>126</sup> Although several LVMPD FIT officers were trained on OIS investigations at the Los Angeles Police Department, this training is not a requirement and has not been completed division-wide, due to recent budgetary constraints.<sup>127</sup> As of August 2012, homicide investigators are given no training on how to conduct an OIS investigation.

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**RECOMMENDATION 7.1:** LVMPD should re-establish a specialized group of investigators designated to conduct comprehensive OIS investigations, in conjunction with the District Attorney's Office, that are legal in nature. These investigators should undergo specialized training.

LVMPD should return to the practice of using a specialized team of investigators to conduct OIS investigations. In order to ensure the accurate, thorough, and fair investigation of OISs, LVMPD officers investigating these incidents should have specialized training and expertise. There are unique circumstances surrounding OISs that make their investigations differ from other criminal investigations. Different interview questions, interviewing techniques, and crime scene analyses may apply.

In response to high numbers of OISs, other police departments have provided their officers with advanced tactical and investigative skills training for assessing officer performance.<sup>128</sup> Being able to thoroughly investigate OISs requires both training and adequate resources.

### **IMPLEMENTATION STEPS:**

1. Review staffing requirements to ensure the creation of a sustainable model.
2. Select officers to participate.
3. Formalize training requirements for all officers who conduct investigations.

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126. LVMPD, *Force Investigation Team Manual* (no date).

127. CNA interviews.

128. Police Assessment Resource Center, *The Portland Police Bureau: Officer-Involved Shootings and In-Custody Deaths*, (Los Angeles, CA: Police Assessment Resource Center, 2003).

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**FINDING 7.2: LVMPD homicide investigators do not consistently video-record all interviews for OISs.**

According to LVMPD's FIT manual, recorded statements from the involved and witness officers are to be taken as part of an OIS investigation.<sup>129</sup> In addition, the manual notes that proper procedure is to take photographs of the involved officer, his/her firearm and the magazine, any evidence and/or injuries to the involved officer, and the suspect's weapons.<sup>130</sup> Any additional photos of the crime scene are taken by the Crime Scene Investigations Section.<sup>131</sup> Although the FIT photographs evidence and records statements, the FIT manual does not require the video-recording of all interviews with witness- and involved-officers.<sup>132</sup>

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**RECOMMENDATION 7.2: As part of their investigatory and interview procedures in an OIS, homicide investigators should video and digitally record all interviews.**

The IACP's model policy on investigating OISs also recommends that "photographs and, where possible, a videotape recording should be made of the overall scene and all pieces of evidence."<sup>133</sup> By incorporating this into its processes and procedures, LVMPD would be more in line with national standards and best practices. Other major city police agencies have adopted this practice.<sup>134</sup>

By doing so, LVMPD can increase public confidence in the investigation and protect agencies from the risk that witnesses will change their stories.<sup>135</sup> Officers conducting these complex investigations can refer back to the video of the interviews throughout their investigation rather than having to refer to their notes and/or recollection. The videos can also provide the investigators with an added perspective that photos cannot provide.<sup>136</sup>

**IMPLEMENTATION STEPS:**

1. Formalize procedures of video-recording all interviews as part of the investigation of a deadly force incident in the LVMPD Policy Manual.
2. The Homicide and Robbery Division and ODB will conduct training on the updated policy and/or provide officers with an overview of the updated policy in a bulletin, roll call, or similar format.

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129. LVMPD, *Force Investigation Team Manual* (no date).

130. Ibid.

131. Ibid.

132. Ibid.

133. International Association of Chiefs of Police, *Investigation of Officer-Involved Shootings: Concepts and Issues Paper*, (Alexandria, VA: International Association of Chiefs of Police, 1999).

134. Police Assessment Resource Center, *The Portland Police Bureau: Officer-Involved Shootings and In-Custody Deaths*, (Los Angeles, CA: Police Assessment Resource Center, 2003).

135. Ibid.

136. International Association of Chiefs of Police, *Investigation of Officer-Involved Shootings: Concepts and Issues Paper*, (Alexandria, VA: International Association of Chiefs of Police, 1999).



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**FINDING 7.3: The Police Protective Association and Police Managers and Supervisors Association have directed their members to not cooperate with deadly force investigations if involved in an OIS.**

The Coroner's Inquest process was established as a means of releasing the facts behind an OIS. It traditionally took place after the DA had made a determination on whether to criminally charge the officer.

In 2010, the Coroner's Inquest process underwent a number of changes in response to a community uproar that called for more transparency and police accountability in OISs. These changes included the addition of an ombudsman, who represented the suspect's family and was allowed to cross-examine the police officer(s) involved in the incident. The changes created concern among the Police Protective Association (PPA) and Police Managers and Supervisors Association (PMSA) that the process had become adversarial rather than a process for releasing information to the public.

As a result, the PPA and PMSA have advised their members to invoke their constitutional rights and not cooperate with or answer any questions from the Coroner's Inquest panel and/or in the FIT investigation of an OIS.<sup>137, 138</sup> This has hampered the FIT investigations and has led to the inaccurate and incomplete investigation of recent OISs. The lack of cooperation from both officers involved and witness officers contributes to a lack of trust in the OIS review process.

In addition, this lack of cooperation can mean that evidence is lost or missing, the investigation is fundamentally flawed, or the responsibility for wrongdoing is inappropriately assigned to the involved officer.<sup>139</sup>

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**RECOMMENDATION 7.3: In order to ensure complete and thorough investigations and engender community trust, the police associations should encourage their officers who are involved in shootings (shooters, witnesses, and supervisors) to cooperate with the OIS investigation.**

LVMPD recently updated its *Post Use of Force Procedures* to state: "Witness Officers are required to provide a recorded statement to FIT investigators. Witness officer statements will be taken at a date, time, and location determined by FIT investigators."<sup>140</sup> However, many involved officers are still refusing interviews. Lack of cooperation in such investigations only cements the public's negative perception of officers and the department as a whole, and may seem to imply wrongdoing on their part. Cooperating with the investigation not only will build trust within the community, it also could support criminal charges against the perpetrator by providing a complete and accurate depiction of the officer's actions.

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137. C. Benka, "DA's Office Reviewing Officer-Involved Deaths," *8 News Now*, April 19, 2012.

138. CNA interviews.

139. International Association of Chiefs of Police, *Investigation of Officer-Involved Shootings: Concepts and Issues Paper*, (Alexandria, VA: International Association of Chiefs of Police, 1999).

140. LVMPD, "Post Use of Force Procedures, PO-021-11," (2012).

**IMPLEMENTATION STEPS:**

1. Engage police associations in a dialogue about officers giving interviews in the event of an OIS.
2. Establish protocols that respect officers' constitutional rights as it relates to self-incrimination.

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**FINDING 7.4: LVMPD does not analyze use of force reporting and data on a routine basis in order to identify department-wide trends and quickly remedy any issues.**

LVMPD has a system for collecting use of force statistics and red flagging patterns of behavior in officers that may indicate something is wrong. This system is known as Blue Team. Blue Team monitors individual officers and is also the source of an annual report on use of force statistics. However, the department does not regularly monitor use of force activity to identify department-wide trends.

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**RECOMMENDATION 7.4: LVMPD should analyze use of force reporting and data on a regular basis in order to identify trends and quickly remedy any issues through remedial training or discipline if needed.**

The department should develop the capability to analyze use of force statistics on a regular basis and report on significant trends. This analysis can be used to modify training modules as appropriate. Additionally, LVMPD should conduct quality assurance checks on use of force reports submitted to Blue Team.

**IMPLEMENTATION STEPS:**

1. Update the LVMPD Policy Manual to reflect new analysis and quality assurance functions with respect to use of force statistics.
2. Identify personnel needs to fulfill the new function.
3. Monitor progress of the new function and update process as appropriate.

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**FINDING 7.5: LVMPD does not conduct a comprehensive review of an officer's training record as part of its administrative use of force investigations.**

CIRT requests the training records of all officers involved, as part of the administrative investigation. However, based on our review of all CIRT administrative reports, the inquiry appears to be limited to the currency of the officer's training, simply listing the date that the officer last met his/her firearm requalification or AOST requirement. This could give a false impression of an involved officer's training history, which might or might not be related to the incident.

**RECOMMENDATION 7.5:** As part of its standard use of force investigations, LVMPD should conduct a comprehensive review of an officer’s training record, to include historical data on training requirements and remedial training.

CIRT should work with University of Metro Las Vegas (UMLV) and AOST to access the historical training records of officers involved in shootings. This will give investigators a more thorough understanding of the officer’s background and career, and will enable them to identify any gaps that need to be addressed by the training bureau or the officer’s supervisor(s).

**IMPLEMENTATION STEPS:**

1. Identify training requirements that align with common tactical and policy issues arising from OISs.
2. Design a standard request form for training records for officers involved in a shooting, to include the following:
  - a. All optional and mandatory training courses
  - b. Remedial training
  - c. Timeframe of training request (i.e., in the previous two years, three years, or more)
  - d. Trainer evaluations for each specified training course
3. Update CIRT Administrative Report template to reflect new training review.
4. Provide CIRT investigators and staff with an overview of the new standard for training reviews in a bulletin, briefing, or similar format.
5. Provide necessary personnel resources to achieve this recommendation.

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**FINDING 7.6:** LVMPD has produced an annual review of OIS statistics and plans to disseminate the report to the public.

The OIS statistical report entails descriptive analyses of OIS incident characteristics. However, there is no requirement that such a report be produced annually.

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**RECOMMENDATION 7.6:** LVMPD should formalize the production and dissemination of an annual report of OIS statistics.

The Las Vegas community has been calling for more information on OISs and other uses of deadly force. Part of the department’s public dissemination strategy should involve the analytic work of CIRT. The CIRT Section Manual should be updated to include the timely production of an annual report on OIS statistics for public dissemination.

**IMPLEMENTATION STEPS:**

1. Formalize the procedures for producing, publishing, and disseminating the annual OIS statistical report in the LVMPD Policy Manual. These procedures should include the following steps:
  - a. Assign responsibility of producing the annual report on OIS to OIO or CIRT staff.
  - b. Gather the statistical information needed to produce the report by working directly with the CIRT analyst and/or ANSEC.
  - c. Develop a timeframe in which to produce, publish, and disseminate the report.
  - d. Draft the statistical report in collaboration with CIRT analyst and/or ANSEC.
  - e. Deliver the report to executive command for review.
  - f. Finalize the report for publication.
  - g. Once published, post the report on LVMPD.com, Facebook, and Twitter.
2. Use the annual report to analyze trends and identify gaps.
3. Disseminate this report both internally and externally in a timely manner.

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**FINDING 7.7: LVMPD’s administrative use of force reporting process does not include review and input from key administrative components.**

The production process for CIRT’s administrative reports has become more formalized over time. The report now has a standardized template that includes the components and subcomponents of a CIRT analysis (summary, persons involved, chronology, etc.). Additionally, CIRT has established timelines for the report writing and a standardized process for editing and review within OIO.<sup>141</sup>

However, the report production process lacks a peer review component from department members outside of OIO. The only point in the CIRT process that other department members can provide input is during the critical incident internal presentation to ODB.<sup>142</sup>

However, partners within the agency can provide important insights for CIRT’s administrative review. For instance, in 17 of the 87 incidents (or 20 percent) since 2007, the CIRP/CIRT review recommended that the department implement a new type of training. The second and third most frequent recommendations were to enhance existing training (14 percent) and to produce interdepartmental studies or reviews on specialized topics (13 percent). The Training Bureau and CIRT would mutually benefit from a Training Bureau review of those recommendations prior to their publication.

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141. LVMPD, *Critical Incident Review Team Section Manual* (2012).

142. *Ibid.*

**RECOMMENDATION 7.7:** LVMPD should formalize a peer review of its administrative use of force investigation reports. Prior to the presentation to the Use of Force Review Board, the report should be validated for accuracy and completeness by the Internal Affairs Bureau, the Training Bureau, Quality Assurance, and legal counsel.

Given the multidisciplinary nature of CIRT investigations and the prevalence of recommendations that could benefit from the review of LVMPD divisions outside of OIO, the department should devise a peer review process for CIRT administrative reports. The role of each peer review should be to give that person's unique insight on issues pertinent to his or her role in LVMPD. Peer reviewers could identify substantive issues surrounding the incident as well as provide input on any recommendation. These peer reviews should be held prior to the release of the OIO Summary Report, and as prudent and necessary, CIRT should modify its report, findings, and recommendations as a result of these reviews. Implementing a peer review process would ultimately enhance the quality and relevance of the report and the findings and recommendations within. Additionally, this would benefit the peer reviewers, as they would have more lead-time in understanding how the outcome of a particular review might affect them.

**IMPLEMENTATION STEPS:**

1. Identify LVMPD components that are frequently impacted by CIRT investigative findings and recommendations (i.e., Training, Internal Affairs, Quality Assurance, Policy and Research, and legal counsel).
2. Recruit peer reviewers from these components.
3. Brief peer reviewers on their roles and responsibilities. The roles and responsibilities include:
  - a. Identifying substantive issues surrounding the incident
  - b. Providing input on any recommendation
4. Update CIRT Section Manual to include the peer review role.

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**FINDING 7.8:** LVMPD standard operating procedures for the Use of Force Review Board are outdated and insufficient.

The current LVMPD Policy Manual only vaguely lists the responsibilities of the primary case investigator, the secretary of the UoFRB, the involved members, the chairman, the sheriff, and the bureau/area commander. LVMPD policy also fails to provide guidance on the roles and responsibilities of those in additional positions on the board, such as citizens and peer officers.

Because they have no guidance on their roles and responsibilities in the form of a manual and/or consistent training, members are left to their own interpretation of why they are on the board and what their role should be. This lack of guidance can degrade their confidence and their ability to give their opinion or ask questions.<sup>143</sup> In addition, LVMPD fails to provide citizens with either

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143. Police Assessment Resource Center, *The Denver Report on Use of Deadly Force*, (Los Angeles, CA: Police Assessment Resource Center, 2008).

retraining or a manual that explains and provides guidance on their roles and responsibilities. This is particularly problematic given that citizens hold the majority vote on the review board and are responsible for determining whether officers have complied with policy. The citizens have only a limited ability to accurately review and seek clarification of a policy that officers will ultimately be held accountable for following.

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**RECOMMENDATION 7.8.1: LVMPD should develop a stand-alone manual for its Use of Force Review Board containing standard operating procedures, the roles and responsibilities of involved parties, and the purpose of the board.**

LVMPD should review the current policy and provide within it more detail on the roles and responsibilities of all individuals who participate on the UoFRB. As the UoFRB process has evolved within the past couple of months, this governing document should also reflect recent modifications to the process (e.g., the chairman is an assistant sheriff and no longer a deputy chief).

**IMPLEMENTATION STEPS:**

1. Consider reformulating the structure and operations of the UoFRB, based on findings and recommendations of this report and feedback from other internal and external stakeholders.
2. Formalize the roles and responsibilities for each member of the Use of Force Review Board in the LVMPD Policy Manual.
3. OIO and ODB will provide officers with an overview of the updated policy in a bulletin, roll call, or similar format.
4. OIO and ODB will conduct a one- to two-hour training session for all commissioned UoFRB members and civilian members on the new manual.

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**RECOMMENDATION 7.8.2: LVMPD should reassess how citizen board members are selected to participate in the Use of Force Review Board process.**

Currently, citizen participation on the LVMPD's Use of Force Review Board is solicited through an advertisement in the newspaper. Once a citizen's application is received, a background check is completed; once accepted, the citizen board member must complete "a prescribed orientation/ indoctrination training, and attend any additional training involving changes in related department rules and regulations."<sup>144</sup> Citizens are then entered into a database and, through a computerized process, are randomly selected to participate on a review board.<sup>145</sup> LVMPD should consider using a grand jury process to select citizens. This process will ensure that citizens are not self-selecting and that they represent a variety of backgrounds with varying degrees of exposure to law enforcement professionals.<sup>146</sup>

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144. LVMPD, "5/109.02, Use of Force Review Board," *LVMPD Policy Manual* (no date).

145. *Ibid.*

146. NACOLE (The National Association for Civilian Oversight of Law Enforcement), "Recommended Training for Board and Commission Members," (2011) [www.nacole.org/resources/recommended-training-board-and-commission-members](http://www.nacole.org/resources/recommended-training-board-and-commission-members).

**IMPLEMENTATION STEPS:**

1. Identify potential citizen participants.
2. Engage with, solicit, and encourage feedback and input from the executive command, public interest groups, community stakeholders, police associations, and legal counsel.
3. Engage with, solicit, and encourage feedback and input from current UoFRB citizen members.
  - a. Citizen members currently serving on the board will be grandfathered into the new process until their term is complete.
4. Formalize the new Use of Force Review Board citizen member selection process in the LVMPD Policy Manual.
5. Announce the new selection process to the members of the board (commissioned and citizen) in a bulletin, roll call/memo, or similar format.
6. Make public the new process through a variety of media.

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**FINDING 7.9:** In the past, the Use of Force Review Board has rarely issued disciplinary or corrective action, due to both structural constraints and a lack of institutional oversight. LVMPD has recently altered the findings structure to allow for recommendations on administrative actions based on policy, supervision, training, and sound tactics.

In an effort to increase police accountability and improve the department by better understanding and grasping the lessons learned from these OISs, LVMPD has altered the findings structure to allow voting members on the board to find officers compliant or non-compliant on policy, supervision, training and tactics. This allows members to broaden the scope of their findings past the point of the shooting and examine the officer's actions prior to the use of deadly force. This change, although recent, has enabled the department to examine not only administrative compliance but also tactical compliance in greater detail and examine the precursors to OIS incidents.

In addition to the new determinations, the chairman of the board is now an assistant sheriff. Assigning an assistant sheriff to preside over the board gives the UoFRB the authority to carry out recommendations for discipline and eliminates the requirement to process a statement of complaint through Internal Affairs and obtain approval from the sheriff.

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**RECOMMENDATION 7.9:** The department should formalize the new functions of the Use of Force Review Board in its policy manual and monitor their continued implementation and impacts.

As this process continues to mature and is formalized into departmental policy, it will allow the department to identify gaps in training, policy, and tactics. Notably, the UoFRB has made two findings of administrative disapproval since the inception of the new findings structure. CNA recommends that LVMPD institutionalize these new processes into departmental policy in order to formalize the standard. In addition, the department should review the level of implementation closely as the new process is standardized. New processes often go through adjustments as minor issues become apparent.

**IMPLEMENTATION STEPS:**

1. Formalize the new functions of the Use of Force Review Board in the LVMPD Policy Manual. These new functions should include the following:
  - a. The new determinations (administrative approval; tactics/decision making; policy violation not directly related to the use of force; policy/training failure; and administrative disapproval)
  - b. The expanded scope of the board that now allows it to review more than just the moment in which force is used
  - c. The assignment of an assistant sheriff as the chairman of the board
  - d. The authority of the UoFRB to now issue discipline
2. Have OIO provide officers with an overview of the updated policy in a bulletin, roll call, or similar format.

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**FINDING 7.10: LVMPD's process for tracking the implementation of UoFRB recommendations is informal and unrefined.**

In June 2012, the OIO designed and implemented the Informal Training Accountability Protocol (ITAP) in order to monitor and ensure the implementation of all policy, training, and tactical recommendations resulting from a CIRT investigation and UoFRB.<sup>147</sup> To manage ITAP, OIO coordinates with CIRT, UoFRB, and bureau commanders to ensure that it has received inputs on what recommendations have been made, including those in terms of training and discipline, and whether they have been implemented. OIO also coordinates the training for officers who were recommended to have remedial training as the result of a UoFRB.

To remedy any noted deficiencies as soon as possible, OIO facilitates training recommended by CIRT prior to the UoFRB if possible. If the UoFRB has additional recommendations, OIO will then facilitate that training or discipline as well. The recommendations from the UoFRB will go to OIO for monitoring and the bureau commander of the officer in question to fulfill the UoFRB recommendations. When the recommendations have been fulfilled, the bureau commander notifies the chief of patrol, who in turn notifies OIO.

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**RECOMMENDATION 7.10.1: LVMPD should streamline the exchange of information between OIO and bureau commanders who are in charge of ensuring that UoFRB recommendations are implemented.**

In its current form, the ITAP feedback loop of information is too disjointed and has too many points of potential failure. When remedial training is recommended by the UoFRB, the Training Bureau should directly notify all interested parties upon completion of the training, as well as the officer's performance. This includes OIO, the bureau commander, the chief of patrol, and UMLV. This can help ensure that all parties are notified immediately and without failure.

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147. LVMPD, *Informal Training Implementation Protocol* (no date).



**IMPLEMENTATION STEPS:**

1. Revise the current ITAP process to reflect the new process for exchange of information with respect to implementing UoFRB recommendations.
  2. Brief appropriate parties on the new roles and responsibilities and the new process.
  3. Include a “complete the training within X days” requirement.
  4. Include a requirement to conduct regular audits to ensure compliance with the ITAP.
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**RECOMMENDATION 7.10.2: LVMPD should update its policy manual to include the ITAP and formalize the process.**

ITAP remains an informal process and does not have any formal, institutional backing. LVMPD should create an order that establishes the process and clearly outlines the roles and responsibilities of interested parties. This can help strengthen the process and ensure its permanence as a feature of LVMPD’s oversight of training and disciplinary actions resulting from OISs and subsequent UoFRBs.

**IMPLEMENTATION STEPS:**

1. Finalize the ITAP process in written format.
  2. Have internal reviewers provide feedback on the process and make adjustments as necessary.
  3. Educate the workforce on the new process and policy through first-line supervisors and a department-wide bulletin.
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**FINDING 7.11: Presentations by LVMPD personnel to the UoFRB, as well as questions by members of the UoFRB, are not perceived as objective.**

In our observations of the board proceedings, we noted that in some ways the initial presentation set the kind of tone that has been described as “police friendly.”<sup>148</sup> We made no finding as to whether this was intentional or unintentional.

In one OIS presented before the board, the primary case investigator’s description of the shooting subject was overtly negative. In six of the presentations that came before the board we were observing, the primary case investigator did not present the history of the involved officers, such as disciplinary actions, training qualifications, or previous incidents (shooting or non-shooting). This was in stark contrast to the history of the shooting subject that was presented, which was not limited to criminal history but, in some cases, included last contact with the police, drug use, and other patterns of behavior. Additionally, leading questions were posed to the involved officer in each UoFRB we observed.

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148. A. Maimon, L. Mower, and B. Hayes, “Deadly Force: When Las Vegas Police Shoot, and Kill,” *Las Vegas Review Journal* (2011).

**RECOMMENDATION 7.11:** LVMPD should mitigate the potential for bias and leading questions, and emphasize the Use of Force Review Board’s objectivity by providing members of the board and presenters with training on how to present information and/or ask questions in a non-biased or neutral fashion.

**IMPLEMENTATION STEPS:**

1. Formalize this new training requirement in LVMPD Policy Manual. Announce this new training requirement to the members of the board (commissioned and citizen) in a bulletin, roll call/ memo, or similar format.
2. Provide members of the board and presenters with mediation training.<sup>149</sup>
3. Conduct audits of the training to ensure it is appropriately and consistently presented.
4. Solicit evaluations of the training from the attendees and modify as needed.
5. Monitor the results of the training, by observing UoFRB, to determine whether it has achieved the desired result of reducing the appearance of bias.

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149. Jurisdictions such as Rochester, New York, train civilians on their review board in mediation. The mediation training exercises they provide encourage participation, which helps board members become aware of their biases and “increases their ability to think impartially.” P. Finn, *Citizen Review of Police: Approaches and Implementation*, (Washington, D.C.: National Institute for Justice, 2001).



## Chapter 8: Use of Force Incident Review

The Coroner's Inquest and the District Attorney's (DA) Office are independent, county functions. With the exception of any federal review or intervention, the inquest and DA's review make up the totality of external review for OISs in Las Vegas. This chapter details the external accountability system for OISs in Las Vegas. Unlike the process discussed in the previous chapters, those described here are not within the control of LVMPD.

### Coroner's inquest

The Coroner's Inquest is the fact-finding procedure that takes place any time an individual dies at the hands of law enforcement. The purpose of an inquest hearing is to "publicly bring forth all of the details surrounding the incident and leading to the death."<sup>150</sup> The Coroner's Inquest process was established in 1976 in Clark County as a result of an increasing need for public transparency in OISs.<sup>151</sup> Since its inception, there have been four changes to the inquest, each with the goal of providing more transparency. Incidentally, many changes to the process have been a direct result of public demands for more information in high-profile OISs.<sup>152</sup>

Demands for more transparency increased because the DA traditionally has neither conducted its own investigation nor released decision letters. In fact, if a criminal charge was ever filed, it was recommended by LVMPD to the DA. If the DA agreed to file criminal charges, the case would go to court and not go to Coroner's Inquest. As a result, the jury often found the cases that did go through the Coroner's Inquest process justified. However, the Coroner's Inquest remained a process in which the public can essentially disagree with the DA's initial decision and recommend criminal charges by finding the officer unjustified.

The latest round of changes came in 2010. The Clark County Board of County Commissioners convened a nine-person advisory committee to study the inquest, make recommendations to address the public's concerns and create an inquest process that would give the families involved the information they wanted.<sup>153</sup>

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150. "Coroner-Medical Examiner: Inquest Review Panel," (Clark County, NV: Clark County Board of Community Commissioners, 2010), [www.clarkcountynv.gov/depts/coroner/Pages/Coroner%27sInquestReviewPanel.aspx](http://www.clarkcountynv.gov/depts/coroner/Pages/Coroner%27sInquestReviewPanel.aspx).

151. CNA interview with Clark County Coroner/Medical Examiner Michael Murphy, February 14, 2012.

152. Ibid.

153. "Coroner-Medical Examiner: Inquest Review Panel," (Clark County, NV: Clark County Board of Community Commissioners, 2010), [www.clarkcountynv.gov/depts/coroner/Pages/Coroner%27sInquestReviewPanel.aspx](http://www.clarkcountynv.gov/depts/coroner/Pages/Coroner%27sInquestReviewPanel.aspx).

As a result, a number of changes were made, including the following:<sup>154</sup>

- An initial pre-inquest conference would now be required. This pre-inquest conference would require all parties to meet prior to the Coroner's Inquest in order to discuss the ground rules and provide an overview of what the inquest would cover.
- Police officers would be required to participate in the inquest by taking the stand.
- An ombudsman, appointed to represent the community and the suspect's family, would be allowed to cross-examine the police officer(s) involved in the incident.
- The jury of citizens would no longer be referred to as a "jury" but would now be called the "Coroner's Inquest panel."
- The panel would only be able to ask questions posed by interested parties and approved by the inquest judge.
- The panel would no longer provide a verdict.
- Legal discovery would now be allowed for all interested parties.

Some of these changes to the process caused police officers and police associations to become more concerned about possible violations of officers' constitutional rights. Police associations have advised their officers to decline answering any questions—a right that officers, like other citizens, are guaranteed by the Fifth Amendment.<sup>155</sup> They believe that the inquest process has become too adversarial and no longer serves as a medium to release the facts behind OISs.

As a result, the Coroner's Inquest has been at a standstill since August 2010; thus, a total of 17 LVMPD OIS cases have not gone through the process. Arguments over exactly what role the Coroner's Inquest holds in police-involved shootings have been taken to the State Supreme Court.<sup>156</sup>

## **District Attorney's office**

Violent confrontations between citizens and police that result in the application of deadly force are among the most important and significant events engaged in by police. The community's perception of these events can have enormous consequences in shaping opinions and attitudes toward police, including perceptions of trust and legitimacy.

Because of past controversial shootings that received extensive media attention, there is currently a belief among community stakeholders that the review process for OISs is broken. Further, it is believed that this broken process results in part from a lack of clarity concerning the role of the DA in OIS criminal investigations, case reviews, and case-filing decisions.

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154. CNA interview with Clark County Coroner/Medical Examiner Michael Murphy, February 14, 2012.

155. "Police Union will Try to Block Coroner's Inquest Changes," *Las Vegas Sun*, June 20, 2011, [www.lasvegassun.com/news/2011/jun/20/report-police-union-will-try-block-coroners-inquest](http://www.lasvegassun.com/news/2011/jun/20/report-police-union-will-try-block-coroners-inquest).

156. B. Haynes, "State Supreme Court Hears Inquest Arguments," *Las Vegas Review Journal*, June 5, 2012, [www.lvrj.com/news/state-supreme-court-hears-inquest-arguments-157371745.html](http://www.lvrj.com/news/state-supreme-court-hears-inquest-arguments-157371745.html).

The role of the DA is to focus solely on the question of criminality and determine whether to charge the officer in question. Even if the DA has extralegal concerns with aspects of the shooting, unless the behavior is determined to be criminal he or she has no administrative or civil authority on this matter. When no criminal charges are filed, it does not necessarily mean that the DA is affirming that the OIS was justified. Rather, it is a determination that there is not enough evidence to meet the “beyond a reasonable doubt threshold” to warrant a prosecution. However, the occurrence of OISs does not diminish the need to uphold the public trust and review each shooting.

The decision to charge an LVMPD officer with a criminal offense as a result of a shooting incident rests with the Clark County DA. Until recently, the practice of the Clark County DA was not to review an officer’s use of deadly force unless the chief executive of a police agency requested it. The DA has relied heavily on the investigation of LVMPD to determine any criminality by the officer involved in the shooting.

However, recently, the newly appointed DA decided that in order to ensure continued public transparency and police accountability, his office would conduct its own review of the 17 cases backlogged by the lack of a Coroner’s Inquest and any fatal OISs that occurred in the future.<sup>157</sup> In April 2012, the DA released its first memorandum of decision.<sup>158</sup> As of June 2012, the DA has released 11 memoranda of decision related to OISs.<sup>159</sup> These memos provide the public with the facts behind each case, by giving details of the incident, summaries of the interviews conducted, and details behind each police action.

## Findings and recommendations

### **FINDING 8.1: The Coroner’s Inquest process related to review of deadly force incidents is ineffective.**

Clark County’s use of a Coroner’s Inquest in OISs is possibly the most publicized in the country. This is partially a result of two things: first, it’s one of a few jurisdictions in the United States that still has a Coroner’s Inquest; second, the State Supreme Court decision on whether to uphold or to continue postponing the inquests is at the forefront of the media and the Las Vegas community.

Only a limited number of jurisdictions across the country require a Coroner’s Inquest for every fatal police shooting. Clark County in Nevada, King County in Washington, and a handful of jurisdictions in Montana are some of the locations that use this process to ensure public accountability among law enforcement agencies. No known standards of practice and procedures exist for such inquests.

157. G. Wingert, “District Attorney Review Finds Two Officer-Involved Shootings Justifiable,” *Las Vegas Sun*, April 19, 2012, [www.lasvegassun.com/news/2012/apr/19/district-attorney-review-finds-two-officer-involve](http://www.lasvegassun.com/news/2012/apr/19/district-attorney-review-finds-two-officer-involve).

158. “District Attorney Decisions,” Clark County, NV, [www.clarkcountynv.gov/Depts/district\\_attorney/Pages/DecisionMemos.aspx](http://www.clarkcountynv.gov/Depts/district_attorney/Pages/DecisionMemos.aspx).

159. *Ibid.*

In previous years, the Coroner's Inquest process was essential in providing the public with transparency because the DA neither conducted its own investigation nor provided the public with the facts or its decision to pursue charges. However, now that the Las Vegas DA is providing memoranda of decision in OISs and providing the public with the facts behind each case, the role of the Coroner's Inquest process is no longer clear.

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**RECOMMENDATION 8.1:** Clark County Commission should review the necessity and purpose of the Coroner's Inquest since it is now being met by the public release of the DA's Memorandum of Decision and the LVMPD OIS review.

The need to hold a Coroner's Inquest in every OIS that results in a fatality should be re-examined by the Clark County Commission. Now that the DA is releasing a memorandum of decision and LVMPD's Office of Internal Oversight (OIO) is releasing an incident summary report, the role of the Coroner's Inquest is unclear and should be reassessed. Modifying or eliminating the Coroner's Inquest process is not under the sole purview of the LVMPD's executive staff; rather, it is left to the agreement of all commission members. Although LVMPD cannot solely initiate changes to the Coroner's Inquest process, it is in the best interest of LVMPD to continue its participation on the panel and pursue changes, both internal and external to the police department, that will achieve public transparency and police accountability.

**IMPLEMENTATION STEPS:**

1. The sheriff should continue to support and initiate organizational changes within the department that promote police accountability and public transparency.

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**FINDING 8.2:** The Clark County District Attorney has begun to review OISs that result in death and to issue decision letters regarding criminal findings. However, decision letters are not issued for serious, non-fatal use of force incidents.

The DA has recently begun reviewing the backlog of OISs, and is moving forward to review criminal investigations of OISs and rendering filing decisions. This fills a major void left by the suspension of the Coroner's Inquest.

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**RECOMMENDATION 8.2:** The Clark County DA's Office should continue to review all fatal use of force cases and consider also reviewing significant uses of force that did not result in death.

The current OIS reviews by the DA are limited to those instances resulting in death of the suspect. Other OISs and serious uses of force are not reviewed. Thus, there is no independent assessment of non-fatal OISs.

**IMPLEMENTATION STEPS:**

1. The DA's Office should review existing statutes, policies, and procedures to determine codification requirements for mandatory reviews of OISs and other significant uses of force, including those not resulting in death.
2. After conducting this review, the DA should meet with the sheriff to discuss changes to its review process of OISs.

**FINDING 8.3: The Clark County DA's Office needs more training and expertise related to investigating deadly force incidents.**

Before the recent changes were made to the Coroner's Inquest proceedings, the DA's Office took no actions prior to the inquest, and relied on homicide reports from LVMPD to determine whether to file any charges.

In the past, the DA's Office has not had a cadre of lawyers or a specialized unit that has routinely handled use of deadly force cases, and the office has played only a minimal role in the investigation of such cases. Yet, the role played by this office in the investigation and review of OISs is critical. If public trust is to be restored, the office needs a better-resourced and well-defined process that is timely, transparent, and grounded in regulation or statute.

**RECOMMENDATION 8.3: The Clark County District Attorney's Office should acquire additional expertise and dedicated resources to investigate OISs more comprehensively.**

We examined of the DA's role in reviewing OISs in other jurisdictions of similar size, and found some variation. Some offices play a major role from the onset in the investigation of the shooting, working closely with local police. Others present investigation findings to grand juries. Still others do even more limited reviews. Denver has recently changed its investigation of OISs in a promising way. Its model was reviewed and strengthened as part of the work of the Erickson Commission, which analyzed Denver's handling of OISs.<sup>160</sup> Criminal investigations of OISs are conducted under a specific investigative protocol, with personnel from the Denver Police Department and Denver DA participating from the outset. These investigations are handled by prosecutors who are specially trained for these cases, and at least two prosecutors are assigned to each case.

We recommend that the DA conduct a needs assessment to identify additional resources required for the investigation and review of all OISs and other significant uses of force. We also recommend that the DA's Office further develop protocols to guide its role in investigating shootings in cooperation with LVMPD FIT, and the subsequent review and issuance of findings. Although resource constraints are a real issue for many jurisdictions, the number of shootings in Clark County justifies some degree of specialization and the building of expertise to handle OIS cases within the DA's Office.

160. Erickson Commission, *Report of the Erickson Commission* (1997), [www.denverda.org/News\\_Release/Decision\\_Letters/Erickson%20Commission%20Final%20Report.pdf](http://www.denverda.org/News_Release/Decision_Letters/Erickson%20Commission%20Final%20Report.pdf).



*Although this recommendation is outside the purview of LVMPD, it is imperative that LVMPD work with the DA to ensure that the above recommendation is implemented.*

**IMPLEMENTATION STEPS:**

1. Conduct a needs assessment to identify additional resources required for the investigation and review of all OISs and other significant uses of force.
2. Develop protocols to guide the DA's role in investigating shootings in cooperation with LVMPD, and the subsequent review and issuance of findings.

## Chapter 9: Community Perspectives and Outreach

This chapter documents our review of the perspectives of the Las Vegas community on LVMPD's use of deadly force. First, we review the community perspectives we gathered through our interviews and discussions with community leaders and stakeholders. We then follow with a series of findings that are general to LVMPD's interaction with the community. Finally, we present recommendations that seek to improve community relations and public transparency, and to develop positive perceptions of LVMPD and its efforts to hold police accountable.

### Background

LVMPD's stated mission is to protect the community through prevention, partnership, and professional service. In pursuit of that mission, officers are required to engage in constitutional policing practices and to be accountable in fulfilling this mission to the community members that they serve. The Civil Rights petition filed by the NAACP and the ACLU in January 2012 cited public concerns about policing patterns and practices, including those related to deadly use of force. These civil rights concerns prompted us to interview various community stakeholders to better understand the source and nature of these concerns, and views on how they should be addressed. Those we interviewed included community leaders and stakeholders who routinely work with LVMPD, including property managers and members of various LVMPD citizen advisory committees, and elected officials, retired police officials, neighborhood leaders, and local ministers. The list of persons to be interviewed was developed in part by asking the NAACP, the ACLU, and the LVMPD who they thought we ought to interview in order to hear various, informed perspectives from the community.

We conducted 42 community interviews. Interviewees expressed various perspectives and opinions, but there were some common themes. First, interviewees had few complaints and considerable praise for LVMPD regarding its effectiveness in attacking neighborhood crime problems and pursuing its public safety mission. Property managers and business owners were especially complimentary. Many cited responsiveness to their concerns and timeliness of response. Among this group, the major complaint was failure to share follow-up information when a police action occurred on or near their properties. Second, many interviewees expressed concern about LVMPD's use of deadly force. The source of much of this concern was, according to the community persons interviewed, shaped by the intense media coverage of controversial shootings in recent years.

Some interviewees from minority communities felt that policing practices in economically distressed neighborhoods with high concentrations of black and Hispanic residents are more aggressive and less respectful of community residents than practices in other parts of Clark County. They complained about rudeness, intimidating behavior, and a lack of sensitivity of some officers. They also raised concerns about the "stop and frisk" practices used. One interviewee believed that this practice was less likely to be applied in upscale neighborhoods where adolescents and young adults exhibit "the same kind of high-risk behavior" observed in economically distressed areas.<sup>161</sup>

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161. CNA interviews.

There were exceptions to these views in the minority communities where community policing practices and community partnerships had been established and were working well. An example is the Sherman Gardens area; a decade ago, it was a high violent crime area and police were viewed with suspicion there. Today there are residents working closely with LVMPD to identify and address crime problems and quality-of-life issues. Police commanders, supervisors, and officers have tried to build trust among community members, demonstrate sensitivity, and respond to community concerns.

Nearly all of those interviewed regarding Sherman Gardens believed progress had been made in police community relations in recent years. However, many still believed that LVMPD might not be trusted to police itself when officers engage in inappropriate behavior, including excessive use of force and deadly force. Of particular concern was the perceived lack of accountability for officers involved in questionable shootings. This perception was caused by the fact that both the internal and external review processes resulted in nearly 100 percent findings of justification. Many believed that the shootings of unarmed, young black males could have been prevented by better police tactics, decision making, and training. They were firm in the belief that the LVMPD leadership has not taken the necessary steps to control the use of deadly force in situations where the shooting by police was perceived to be preventable.

Many of those interviewed attributed questionable shootings to three common factors: officers operating out of fear because they fail to understand those they serve; inadequate police training; and having police leadership that tolerates lapses. One former police official felt that the current LVMPD leadership team has failed in this regard, stating “they are not consistently vocal enough in demanding accountability for officer excessive use of force violations.”<sup>162</sup>

Another consistent theme among community spokespersons was that when questionable or preventable shootings by police are not subject to a thorough and objective review, they can generate controversy. This can be a major factor that undermines trust in police and their legitimacy.<sup>163</sup>

Recent controversial shootings and media scrutiny have reinforced the lack of trust among many Las Vegas/Clark County residents. One senior elected official was particularly outraged and asked, “How is it possible that an officer who was involved in multiple previous shootings with two resulting in death and one being highly questionable, and where a series of policy violations were also noted, is still being employed by LVMPD?” A prominent community leader simply stated, “LVMPD has not demonstrated a capacity to police itself.” Adding to this distrust and the perception that LVMPD is not holding its officers accountable are the current breakdowns in the review of shootings, because of the refusal of police officers to participate in Coroner’s Inquest proceedings.

LVMPD has taken noteworthy steps to reach out to community stakeholders in various forms. For instance, the department holds regular meetings with leaders from the black and Hispanic communities. The department has also revised its use of force policies, incorporating many of the recommendations from community stakeholder groups including the NAACP and the ACLU. In terms of communicating facts of OISs with the public, LVMPD has just recently, in July 2012, begun to release summary findings from both its FIT and OIO reports in order to provide greater transparency of its review and internal adjudication processes.

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162. CNA interviews.

163. T. Tyler, Presentation at U.S. Department of Justice, Office of Community Oriented Policing Services (COPS Office) Conference, Bethesda, MD (2012).

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## Findings and recommendations

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**FINDING 9.1:** The information LVMPD provides to the public on the circumstances of OISs is not meeting community expectations and is contributing to the public's negative perception of LVMPD.

The progress that LVMPD is making in improving police accountability is readily apparent to those who regularly visit the department's website and those who happen to stumble across it. However, the LVMPD is not proactively responding to potentially negative stories presented by the media. This delay or gap in communications can have the same effect as not releasing detailed information or only using one communication method to release information. Although the department is making strides to increase public transparency by providing the public with internal reports that detail the circumstances of OISs and by releasing updates to its Use of Force policies, these are just the first steps in regaining public trust.

Currently, LVMPD releases information on OISs on its website, which is a very limited mode of dissemination. In addition, press releases often lack sufficient detail to support the contention that a thorough and competent investigation is being done. The lack of information in these press releases can leave the community wondering what the suspect did to be considered "suspicious" by the officer and what prompted the suspect to run. It also raises the question of why the officer shot a suspect who was running away. The lack of factual detail leads the public to falsely assume the circumstances behind the incident or pass along unsubstantiated rumors.

Further adding to this issue is the absence of police accountability. Current press releases from LVMPD do not identify what departmental entity(ies) will be reviewing the incident; nor do they make a statement of the department's intent to review the incident for compliance with its Use of Force Policy. Thus, community members are left to wonder whether the police officer will ever be held accountable for shooting a person in a situation where many believe other options were available.

The department can prevent rumors by actively delivering more detailed and timely information on the incident and on what the department is doing to ensure compliance with policies. Through this delivery of information, the department will also provide both the media and the public with factual details, preventing questions about the police officer's decision to use deadly force.

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**RECOMMENDATION 9.1:** LVMPD should work with community leaders and other stakeholders to establish mutual expectations and a process for the release of information to the public following an OIS.

Individual officers also play a role in building trust with their community through their daily interaction with the public. Community-oriented policing (COP) officers and area command crime prevention specialists play a large role in engaging the community on a day-to-day basis. Building on current outreach strategies (e.g., town hall meetings) and relationships will only increase public trust and build a positive rapport, which is especially important in offsetting and reducing the potential for negative reactions to police actions in deadly force incidents.

**IMPLEMENTATION STEPS:**

1. LVMPD should partner with community leaders and other stakeholders as it implements the reforms described in this report. This partnership could include:
  - a. A Town Hall-like meeting where the community is invited to hear an overview of the report upon its release
  - b. Selected focus groups on the impact of the reforms
  - c. Community engagement sessions in selected neighborhoods to enhance officer-citizen relationships
2. After incidents involving deadly force, Executive Command and area commanders should instruct a designated LVMPD representative to do the following:
  - a. Attend community meetings to clarify misconceptions about police actions, dispel rumors, and provide community members with accurate information regarding the incident.
  - b. Meet with local community stakeholders regarding their concerns and reiterate the actions the police department is taking to hold police accountable.
  - c. Host town hall meetings and provide residents with information on the case (as it is appropriate for release) and discuss what the department is doing to investigate the incident fully in order to ensure that any officer(s) found to have violated policy and/or procedure will be held accountable.
  - d. Brief key community leaders to assist with and support officer/command presentations (within the law and considering the integrity of the investigation and privacy).
3. Distribute the press releases of the incident to local community members who have expressed concern over the incident.
4. Formalize the above procedures in the LVMPD Policy Manual.
5. OIO and ODB will conduct training on this new policy and procedure and/or provide designated LVMPD representatives with an overview of the updated policy in a bulletin, roll call, or similar format.

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**FINDING: 9.2: LVMPD is now releasing deadly force investigation summary reports in response to community concerns about the perceived lack of accountability for officers involved in OISs.**

The central concern raised by community members was the perceived lack of accountability for LVMPD officers involved in OISs, and especially those resulting in a fatality. Only in rare instances have officers in the past been disciplined for deviations from policy. In the past, Coroner's Inquest proceedings at least provided an opportunity to air the facts and circumstances surrounding the shootings. Now, although the District Attorney (DA) releases findings that address any criminal intent or negligence, the Coroner's Inquest has halted, and the general public is left with little or no explanation as to what happened and whether any deviations from policy occurred.

Recently, LVMPD has started releasing use of deadly force summary reports that address both potentially criminal and administrative issues and determine any policy deviations. The release of this information does not include disciplinary actions or other outcomes for officers found to be in violation of Use of Force Policy. This recently established practice has no formalized basis; nor does the release of these reports provide an opportunity to question LVMPD officials about their findings.

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**RECOMMENDATION 9.2: LVMPD should create a policy to institutionalize the process that is now providing greater transparency of its police operations and internal reviews relating to use of deadly force.**

LVMPD has made significant changes that enhance the transparency of the OIS review process. We recommend that release of this information be continued and formalized. However, we acknowledge the legal parameters associated with the release of information concerning disciplinary actions. The LVMPD sheriff or sheriff's designee needs to have an open line of communication with the community within a reasonable time period to disclose what is known and what remains to be investigated. Barring exigent circumstances, this communication should occur within 72 hours of the incident. What is important about the department's communication is that it is a two-way dialogue with the community. Other platforms, such as more detailed press releases, monthly newsletters, community meetings, flyers, and newspaper articles, should also be considered as methods to release information to the public.

**IMPLEMENTATION STEPS:**

1. Formalize the procedures for the public release of information following an OIS in the LVMPD Policy Manual.
2. Engage with LVMPD police officer associations to consider employee concerns and ensure that the procedures do not compromise officer privacy.
3. OIO and the Public Information Office (PIO) will provide officers with an overview of the updated policy and procedures in a bulletin, roll call, or similar format.

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**FINDING 9.3: LVMPD currently lacks standards and procedures for releasing information on OISs to the media and the public.**

LVMPD does not have a formal media strategy for dealing with OISs. Its general media procedures call for the release of public information in accordance with the Nevada Revised Statute 239.010, which declares that public books and public records must be open to inspection.

LVMPD's informal media strategy also includes the following procedures:

- Fostering and maintaining relationships with the media and community partners
- Recognizing the mistakes made and developing and implementing mitigation strategies in response to these mistakes
- Holding press conferences to deliver consistent and timely messages to the media
- Attending editorial meetings with local media sources
- Posting information on LVMPD.com, YouTube®, Facebook, and Twitter
- Advancing non-breaking news stories that are positive and promote LVMPD's various community projects, safety messages, and partnerships via the community relations specialist

In cases where an officer is involved in a shooting, LVMPD uses the following informal protocol:

- The Public Information Officer (PIO) sends out a press advisory notifying the media of the upcoming press briefing to be held at the scene.
- The deputy chief on scene addresses the media.
- Press releases are posted to the LVMPD website within 24 hours. If the incident is very dynamic, a press conference is held within hours or on the following day.

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**RECOMMENDATION 9.3: LVMPD should develop a formal communications/media strategy for OISs.**

After an OIS, it can be complex and challenging to determine what level and type of information to release to the public when the entire spectrum of facts may not yet be available. Police departments use media/communications strategies to outline more comprehensive and detailed procedures for releasing public information to the media after an OIS or any high-impact incident.

Although LVMPD has informally established procedures for releasing information to the media after an OIS, it should formalize these procedures in a written document. Coupled with training, these procedures will make certain that all members of the executive command and personnel within the PIO's office understand how best to strategically respond to the media.

**IMPLEMENTATION STEPS:**

1. Formally draft a communications/media strategy for deadly force incidents. This strategy document should be referenced in the LVMPD Policy Manual, but should also serve as a stand-alone reference document.
2. The PIO, in collaboration with the OIO, should develop and provide notifications on this new communications strategy to its officers via roll call and/or bulletins.

**FINDING 9.4: LVMPD has publically expressed its commitment to providing officers with wearable cameras.**

Building community trust begins with greater transparency of police operations, especially incidents involving use of force. Video documentation of deadly use of force incidents would undoubtedly improve LVMPD's capability to review the most serious of incidents—those potentially involving the loss of life.

Some police agencies have recently equipped some of their officers with wearable cameras to record and capture all police/citizen encounters. Cities that have used them or are considering their use include Oakland, San Jose, San Francisco, Seattle, Phoenix, Austin, and Louisville. Justifications for their use often boil down to the desire to provide a factual account of police-citizen interactions. Advocates of wearable cameras believe that doing so would result in fewer false accusations as well as fewer negative and potentially unnecessarily violent interactions—presumably because being filmed would serve as a deterrent to both officers and citizens. Advocates believe that this would serve to strengthen trust between the community and police.

Some jurisdictions have noted cost concerns in deciding whether to deploy this technology. Police associations and some of their members argue that with the financial challenges facing the LVMPD, this is not the time to invest millions of dollars in an unproven technology. Opponents might also express both logistical and legal challenges to using this technology. Logistical challenges include developing procedures governing use; data storage; training; access to videos; and cost implications.

**RECOMMENDATION 9.4: Wearable camera technology is relatively new, and further research is still needed regarding its efficacy. LVMPD has invested in this innovative technology and should collect operational data and evaluate its effectiveness in the field. Lessons learned from this pilot will not only benefit LVMPD and its community, but should also be shared with departments across the country to help inform their decisions to invest in this technology.**

LVMPD is exploring the possibility of deploying wearable cameras in two of its command areas. LVMPD should make sure that adequate data is collected to determine the impact, including the effect on OISs, complaints, and civil liability outcomes.



**IMPLEMENTATION STEPS:**

1. Executive Command should designate a team within ODB to coordinate and pilot the wearable camera technology. This team should do the following:
  - a. Review and meet with other departments that have piloted wearable cameras.
  - b. Conduct an assessment of available technology and determine an appropriate vendor for the equipment.
  - c. Identify lessons learned from these departments and incorporate these into the planning and implementation process.
  - d. Consult with stakeholders, such as police officers, executive command, legal advisors, police associations, and community stakeholders.
  - e. Establish a timeframe for the pilot program.
  - f. Establish the goals and objectives of this pilot program. These goals and objectives can include:
    - i. Lowering the number of citizen complaints
    - ii. Increasing public transparency
    - iii. Increasing positive interactions among the police and their communities
    - iv. Increasing police accountability
    - v. Defending police against false complaints
    - vi. Providing training lessons
    - vii. Future development of policy and procedures
  - g. Draft the policies and procedures that officers should follow when using the wearable cameras, including the following:
    - i. Process for retaining/archiving the recordings and chain of custody issues
    - ii. Whether and when to use the camera
    - iii. Use of personally-owned wearable cameras
  - h. Train officers on the policies and procedures of using the wearable cameras.
    - i. Train supervisors on the policies and procedures of using the wearable cameras to ensure the proper use of the cameras by their officers.
  - j. Review and analyze the data for trends on a quarterly basis.
  - k. Deliver reports on this analysis to executive command on a quarterly basis.
  - l. Confer with executive command and decide whether to discontinue the pilot or formally implement wearable cameras into the department.
  - m. Release the analytical findings of the pilot program and the executive command's decision to the department and public.

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**FINDING 9.5: LVMPD's Sherman Gardens community policing model has proven to be effective at enhancing police-community partnerships within that neighborhood.**

Community members and officers we interviewed expressed much satisfaction with the level of cooperation between the community and LVMPD in Sherman Gardens. This initiative employs a community policing approach in the Sherman Gardens neighborhood of the Bolden Area Command. The Sherman Gardens Initiative began in 2007 and crime figures have changed favorably since that time.<sup>164</sup> Violent crimes, including homicides, have declined sharply. Neighborhood residents and LVMPD attribute the change as one of the initiative's successes. Although initial figures are promising, a rigorous evaluation has not been conducted to determine the impact of the initiative on crime. However, our interviews, observations, and understanding of the program indicate a qualitative difference in the level of police-community partnership in Sherman Gardens.

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**RECOMMENDATION 9.5: LVMPD should develop community policing strategies similar to those used in Sherman Gardens and apply them to high crime neighborhoods in an effort to enhance police-community partnerships across the city.**

LVMPD should begin by identifying one other neighborhood that can benefit from greater community partnerships and apply the principles used in the Sherman Gardens Initiative to that location. Doing so will help the department determine the viability of this policing approach to other neighborhoods within Las Vegas. The department should evaluate the program as necessary to determine any impacts on crime and community perceptions of the police.

**IMPLEMENTATION STEPS:**

1. Convene a planning team to identify and transition core community policing principles from Sherman Gardens to another development in Las Vegas.
2. Identify other location(s) for implementing community policing initiative.

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164. D.A. Reyes, *Safe Village: Reducing Violent Firearms and Gang Related Crime in West Las Vegas*, (LVMPD, 2011).



## Chapter 10: Conclusion and Next Steps

The first significant step in changing the culture and patterns of practice among LVMPD officers was taken by the sheriff when he accepted the technical assistance of the COPS Office in an effort to reduce the number of OISs. The scale of the changes needed would be difficult for any large, metropolitan policy agency to implement without technical assistance.

Over the past six months, we reviewed LVMPD policies, procedures, training, and accountability systems. In the process, we interviewed 95 personnel and community stakeholders and reviewed external organizations that directly affected accountability and public transparency in OISs. These external organizations included the Clark County Coroner's Office, the Las Vegas DA, and a number of community stakeholders, such as the ACLU and NAACP.

The recommendations and implementation steps identified in this report seek to improve LVMPD's accountability systems, policies and procedures, training programs, and overall public transparency. In addition, these recommendations, once fully implemented, will play a large role in reducing the number of shootings; reducing the number of persons killed as a result of OISs; transforming LVMPD's organization and culture as it relates to deadly force; and enhancing officer safety.

### Next steps

The U.S. Department of Justice and COPS Office will work with LVMPD in the coming months to ensure that these recommendations are implemented successfully and in a timely fashion. The reforms and recommendations matrix in Appendix A consolidates the findings and recommendations documented throughout the report. In addition, this table summarizes the steps that LVMPD will need to take in order to implement the recommendations. Six months after the release of this report, the DOJ and COPS Office will use the implementation matrix to document the progress of these recommendations and note whether LVMPD has met the goals established at the beginning of CNA's review. Addressing these recommendations will help LVMPD undertake the change in organizational culture necessary to reduce OISs.



## Appendix A: Reforms and Recommendations Matrix

The table below includes the reforms, findings, recommendations, and implementation steps found in this report.

### Organizational reforms

No.	Finding/Issue	Recommendation and Implementation Steps	Status
1	The LVMPD did not have a command official responsible for managing use of force reforms.	LVMPD should designate a single command official responsible for managing use of force reforms. This command official should be the primary liaison to the community, U.S. Department of Justice, and other stakeholders. This individual should report directly to the sheriff.	Completed February 2012. Captain Kirk Primas was appointed to this position.
2	The LVMPD did not have an organizational structure to facilitate use of force reforms.	LVMPD should create a formal organizational structure to facilitate use of force reform and enhance accountability. The sheriff created the Office of Internal Oversight (OIO), headed by the command official responsible for managing the department's use of force reforms. OIO's mission is to significantly reduce deadly force incidents.	Completed February 2012.
3	The LVMPD needed to revise and reform its deadly force review processes (both administrative and legal in nature).	LVMPD should develop the capacity to conduct comprehensive deadly force reviews (both administrative and legal in nature). The LVMPD created the Critical Incident Review Team (CIRT) to conduct administrative investigations of deadly force incidents. The LVMPD also created a Force Investigation Team (FIT) model to conduct legal investigations of deadly force incidents, but it was later disbanded with the responsibilities shared among Homicide investigators. (See Recommendation 53.)	CIRT established July 2010; FIT model initially established October 2010.
4	To identify deadly force and OIS gaps, the LVMPD needed to consolidate units that deal with training and administrative investigations and ensure that lessons learned from OIS incident reviews were incorporated back into training.	LVMPD should consolidate units that deal with training and administrative investigations to ensure consistent and better communication about lessons learned from deadly force incidents. LVMPD created the Organizational Development Bureau (ODB) to strengthen communications among the Quality Assurance Unit, CIRT, and the Training Bureau. This included Academy staff, Advanced Officer Skills Training (AOST), the LVMPD Firearms Range, Quality Assurance, Emergency Vehicle Operations Course (EVOC), and CIRT. CIRT investigations were later moved into OIO.	Completed January 2011.
5	The LVMPD needed to raise the level of executive involvement in the management of the Use of Force Review Board.	LVMPD should raise the level of executive involvement in the management of the Use of Force Review Board. The Use of Force Review Board (UoFRB) is comprised of police officers and civilian members of the community LVMPD serves. Historically, a deputy chief chaired the UoFRB. As of June 2012, the sheriff assigned the higher ranking assistant sheriff of Law Enforcement Operations as the chairman of the UoFRB. This change raises the level of accountability for all incidents being reviewed in the future.	Completed June 2012.

## Five-year detailed analysis of LVMPD, 2007–2012

No.	Finding/Issue	Recommendation and Implementation Steps	Status
6	The number of Officer-Involved Shootings has declined since the third quarter of 2010.	<p>LVMPD should continue to implement reforms, monitor the progress of these reforms, and evaluate their impact on officer-involved shooting (OIS) incidents.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Convene key stakeholders to design performance metrics for key LVMPD initiatives.</li> <li>2. Develop data collection plans for each program.</li> <li>3. Reassess performance metrics periodically to ensure they are capturing the most pertinent data.</li> <li>4. Analyze performance metrics to identify positive and negative trends.</li> <li>5. Conduct annual reviews of programs, using performance metrics, and make adjustments as appropriate.</li> </ol>	Recommended October 2012.
7	LVMPD does not conduct department-wide fair and impartial policing training that includes a focus on deadly use of force. In addition to the community perception of biased interactions in incidents of deadly force, review of agency data found that seven out of 10 (70 percent) OISs involving unarmed suspects were black. Furthermore, six of nine (66 percent) OISs that began as officer initiated stops involved black suspects.	<p>LVMPD should be proactive with respect to fair and impartial policing and provide commanders, supervisors, and officers with advanced, specialized training that includes an emphasis on deadly force decision making.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Work with Human Resources/Personnel and Fiscal staff to determine the necessary resources and a means of conducting this training.</li> <li>2. Identify appropriate trainers to be registered for a train-the-trainer course in Fair and Impartial Policing.</li> <li>3. Develop a training plan to train the officers, supervisors, and commanders.</li> <li>4. Incorporate this training into training academy curriculum for all future hires, recruits, and supervisors.</li> <li>5. Work with Nevada Peace Officers' Standards and Training (POST) to have the course certified for future training reimbursement.</li> <li>6. Develop and approve measures of performance for the trainers, students, and supervisors.</li> <li>7. Develop and implement an evaluation plan for fair and impartial policing and make appropriate changes in training delivery based on evaluations and feedback from the participants, supervisors, and training audits.</li> </ol> <p>LVMPD should also offer advanced training in procedural justice to officers at all levels of the organization and in the academy.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Identify procedural justice training curricula that can be offered to LVMPD officers.</li> <li>2. Encourage all supervisors to take procedural justice training.</li> <li>3. Work with Nevada POST to have the course certified for future training reimbursement.</li> <li>4. Update training requirements to reflect procedural justice training as partial fulfillment of annual POST requirements.</li> <li>5. Incorporate training into future academy classes.</li> </ol>	Recommended October 2012.

No.	Finding/Issue	Recommendation and Implementation Steps	Status
8	Officer initiated stops are more likely to result in a shooting of an unarmed suspect than any other type of contact.	<p>LVMPD should conduct uniform training on the legal parameters of officer-initiated contacts (e.g., consensual stops and investigative detention) throughout the department, starting with proactive entities such as the Gang Crimes Bureau. LVMPD has created training videos on constitutional policing issues (see Recommendation 34). LVMPD should continue to incorporate additional training on this topic into scenario-based and role-playing training modules.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Engage police officer associations, legal counsel, and training staff in developing an officer-initiated activity training module.</li> <li>2. Design scenarios that include consensual stops, investigative detentions, and arrests.</li> <li>3. Design evaluation protocol.</li> <li>4. Identify scheduling and staffing needs to ensure that the whole department is trained uniformly and in a timely fashion.</li> <li>5. Update training requirements to include officer-initiated activities.</li> <li>6. Educate workforce on new training requirements.</li> </ol>	Recommended October 2012.
9	LVMPD policy does not require that supervisors respond to calls for service that involve an armed person or persons.	<p>LVMPD should have a policy that requires supervisors to respond to any call for service that involves an armed person or persons.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Establish a contingency plan for when supervisors are unavailable at the time the call is dispatched.</li> <li>2. Convene executive staff and police associations to discuss new requirement and outline confines of a new policy.</li> <li>3. Publish a policy that requires supervisory response to calls involving armed persons.</li> <li>4. Educate the workforce through training and awareness bulletins on the new requirement, including all supervisors, line officers, analysts, and dispatchers.</li> <li>5. Monitor the computer aided dispatch (CAD) system for compliance with the new policy.</li> </ol>	Recommended October 2012.



## Use of force policy and procedures

No.	Finding/Issue	Recommendation and Implementation Steps	Status
10	The LVMPD Use of Force Policy was deficient and a comprehensive revision was required.	LVMPD should develop and implement a new Use of Force Policy. The LVMPD recognized the need for improvement in its use of deadly force and began an extensive review of its Use of Force Policy in February 2012. It was apparent that the policy needed reform. The changes made to LVMPD's Use of Force Policy were driven by several factors, including the Ninth U.S. Circuit Court, which has jurisdiction over Nevada, and LVMPD's own internal review process, which clearly indicated changes were needed. A fully revised Use of Force Policy was developed and implemented. Key reforms that were made to the policy are included in this matrix along with new recommended modifications.	Completed June 2012.
11	The new Use of Force Policy complies with constitutional standards and model guidelines.	<p>LVMPD should review and update its Use of Force Policy at least annually and as needed to incorporate recent court decisions, analysis of use of force data, and lessons learned from incidents in Las Vegas and other jurisdictions.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Formalize the policies and procedures for the Office of Internal Oversight in the LVMPD Policy Manual chapter that reviews the organization.</li> <li>2. Formalize the annual review and update the process in the LVMPD Policy Manual.</li> </ol>	Recommended October 2012.
12	The new Use of Force Policy is comprehensive; however, the format is cumbersome and not structured in a clear and concise manner that allows officers to quickly apply guidance in the field.	<p>LVMPD should separate its Use of Force Policy into several smaller, specific policies. This should include a core policy that serves as the foundation for the other related policies. Examples of stand-alone policies include rifles, shotguns, and other firearms; ECDs; less-lethal shotguns; batons; OC spray; and other less-lethal weapons.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Ensure essential elements are included in the core Use of Force Policy.</li> <li>2. Draft specific stand-alone policies.</li> <li>3. Develop an education and dissemination plan to ensure continued understanding and adherence to the new Use of Force Policy reforms.</li> </ol>	Recommended October 2012.
13	The LVMPD did not have a "sanctity of human life" statement in its Use of Force Policy.	LVMPD should implement a "sanctity of human life" statement. LVMPD policy now clearly states: "It is the policy of this department that officers hold the highest regard for the dignity and liberty of all persons, and place minimal reliance upon the use of force. The department respects the value of every human life and that the application of deadly force is a measure to be employed in the most extreme circumstances."	Completed June 2012.

No.	Finding/Issue	Recommendation and Implementation Steps	Status
14	The “objectively reasonable” standard in the LVMPD Use of Force Policy was not clear.	<p>LVMPD should clarify the “objectively reasonable” factors in the Use of Force Policy. In the past, guidance on “objectively reasonable” was something that was cited by making reference to U.S. Supreme Court Case <i>Graham v. Connor</i> and other applicable case law. In the newly revised policy, the expanded list of factors that go into determining what “objectively reasonable” is make it clear to officers what factors to weigh when deciding whether force is required. The three factors in <i>Graham v. Connor</i> remain in the policy; however, LVMPD has added an additional five factors to guide use of force decision making:</p> <p><b><i>Graham v. Connor:</i></b></p> <ol style="list-style-type: none"> <li>1. The severity of the crime</li> <li>2. Whether the subject poses an immediate threat to the safety of the officers or others</li> <li>3. Whether the subject is actively resisting arrest or attempting to evade arrest by flight</li> </ol> <p><b>Additional factors to be considered:</b></p> <ol style="list-style-type: none"> <li>1. The influence of drugs/alcohol or the mental capacity of the subject</li> <li>2. The time available to an officer to make a decision</li> <li>3. The availability of officers/resources to de-escalate the situation</li> <li>4. The proximity or access of weapons to the subject</li> <li>5. The environmental factors and/or other exigent circumstances</li> </ol>	Completed June 2012.
15	The LVMPD needed to create an “Intermediate Force” level.	LVMPD should develop an Intermediate level of force. This newly defined level of force handed down by the Ninth U.S. Circuit Court of Appeals significantly changed the way officers should employ some of their weapons, specifically: batons (when used as intermediate force), OC Spray, and Electronic Control Devices (ECD). LVMPD policy now clearly puts the use of these less-lethal weapons into “Intermediate Force” and more clearly defines when they are appropriate to use based on the subject’s actions and the eight objectively reasonable factors.	Completed June 2012.
16	The LVMPD needed to revise its use of force model.	LVMPD should develop a new use of force model. A new use of force model was implemented to replace the traditional use of force “wheel” model. The new model clearly identifies the level of force (used by officers) paired with the level of resistance (used by the suspect). It also incorporates the practice of de-escalation and force transition. This model is intended to comply with the Ninth U.S. Circuit Court of Appeal’s analysis of use of force and to give better guidance to officers.	Completed June 2012.
17	The LVMPD needed to revise its less-lethal shotgun policy to better manage its deployment.	LVMPD should revise the less-lethal shotgun policy. LVMPD made significant changes to policies governing the use and supervision of the less-lethal shotgun. In February 2012, the policy was revised to require that officers announce a warning to the subject and other officers of the intent to deploy the less-lethal shotgun if the subject does not comply with commands. As of June 2012, the policy identifies the level of control in which this tool can be used and includes approved and disapproved uses of the less-lethal shotgun.	Completed February 2012 and June 2012.

**COLLABORATIVE REFORM MODEL**

A Review of Officer-Involved Shootings in the Las Vegas Metropolitan Police Department

No.	Finding/Issue	Recommendation and Implementation Steps	Status
18	The LVMPD determined that it needed to emphasize de-escalation in its Use of Force Policy.	LVMPD should emphasize de-escalation in the Use of Force Policy. The LVMPD Use of Force Policy defines de-escalation and implements a model stressing de-escalation. The policy now makes it clear that de-escalation is a method officers should consider and use in a potentially violent situation. In addition, the policy also notes how important de-escalation can be and how it can be used in certain situations.	Completed June 2012.
19	The LVMPD needed to require its officers to intervene when observing excessive force.	LVMPD policy should require a duty to intervene when witnessing excessive force. The revised policy states, "Any officer present and observing another officer using force that is clearly beyond that which is objectively reasonable under the circumstances shall, when in a position to do so, safely intercede to prevent the use of such excessive force. Officers shall promptly report these observations to a supervisor."	Completed June 2012.
20	The LVMPD needed more stringent parameters for the use of Electronic Control Devices (e.g., Tasers).	LVMPD should implement more stringent parameters for the use of Electronic Control Devices (ECD). The appropriate use of an ECD was defined and placed into the Intermediate Force category. However, significant changes have been made in a revised policy. Specifically, the policy now states: <ul style="list-style-type: none"><li>• The intentional use of more than one ECD simultaneously on the same subject is prohibited (March 2011).</li><li>• When displaying an ECD, officers will give a warning, when practical, to the subject and other officers before firing the ECD. The officer shall give the subject a reasonable opportunity to voluntarily comply (June 2012).</li><li>• Officers are not authorized to draw or display the ECD except for training and inspection, unless the circumstances create a reasonable belief that use may be necessary. The ECD will be handled in the same manner as a firearm and will be secured prior to entering any detention facility (June 2012).</li><li>• Initial use of the ECD shall be a standard 5-second cycle, and then the officer will evaluate the need to apply a second 5-second cycle after providing the subject a reasonable opportunity to comply. Each subsequent 5-second cycle requires separate justification. Once the subject has been exposed to three cycles, the ECD shall be deemed ineffective and another use of force option will be considered, unless exigent circumstances exist (June 2012).</li><li>• The Police Area Lieutenant/Watch Commander will respond to the scene if serious bodily injury resulted from the use of the ECD, or as otherwise advisable (June 2012).</li></ul>	Completed March 2012 and June 2012.
21	The LVMPD needed to further restrict when officers may shoot at a moving vehicle.	LVMPD should implement restrictions on when officers may shoot at moving vehicles. The LVMPD policy was changed to read, "Department members are not authorized to discharge their firearm, either at or from a moving vehicle, unless it is absolutely necessary to do so to protect against imminent threat to life of the member or others. The imminent threat must be by means other than the vehicle itself."	Completed February 2011.

No.	Finding/Issue	Recommendation and Implementation Steps	Status
22	The LVMPD needed to develop a policy governing foot pursuits.	LVMPD should develop a foot pursuit policy to establish parameters surrounding decision making and officer safety. In early 2011, LVMPD developed a foot pursuit policy that details the factors to consider when deciding to engage in a pursuit, officer safety concerns, and transitioning from pursuit to apprehension. The policy also details the roles and responsibilities of: the officer initiating the pursuit, assisting officer(s), supervisor, and dispatcher. The department distributed a training video that discussed various tactics to stay safe and alert during foot pursuits.	Completed February 2011.
23	The LVMPD needed to establish more stringent parameters regarding police rifle deployment.	<p>LVMPD should institute more stringent parameters on police rifle deployment. The LVMPD added requirements in its Use of Force Policy specific to the deployment and tactical use of the rifle including:</p> <ul style="list-style-type: none"> <li>• Officer must announce intent to deploy the rifle via the radio and receive an acknowledgment from dispatch</li> <li>• Whenever possible, officer must deploy the rifle using a two-officer team (one being a cover officer)</li> <li>• Officer must advise dispatch, via the radio, of whether or not deploying officer is accompanied by a cover officer</li> <li>• Communications will re-broadcast that a rifle has been deployed and notify the area supervisor of the deployment</li> <li>• Supervisors must manage rifle deployment on the scene</li> <li>• Officer must use discretion when deploying and displaying the rifle, and to only deploy the rifle when the situation dictates. The officer must be aware of the number of rifles already deployed</li> </ul>	Completed February 2012.
24	The LVMPD had no policy governing weapon-mounted flashlights.	<p>LVMPD should implement a weapons mounted flashlight policy. After review of a critical incident in January of 2011, the LVMPD identified that there was no policy governing weapons mounted flashlights. LVMPD policy was revised to read:</p> <p>“Flashlight Mount: the only approved flashlight mounts will be those that do not affect the functionality of the weapon. It is recommended that officers contact range armorers prior to selecting a flashlight mount to ensure compatibility. Flashlight mounts must be inspected by the Firearms Training and Tactics Unit (FTTU) prior to mounting.”</p>	Completed November 2011.
25	The evaluation component of LVMPD’s Use of Force Policy is inadequate. The department does not focus on department-wide trends, which could highlight problem areas that need to be addressed more thoroughly.	<p>LVMPD should develop a greater data collection and evaluation capacity for all use of force policies throughout the department and should use that data to identify and proactively address any deficiencies.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Determine IT needs for centralized use of force policy database.</li> <li>2. Assign staff as needed for management, analysis, and reporting functions with respect to use of force policies.</li> <li>3. Update the policy manual as necessary to formalize the new data collection process, analysis, and reporting functions.</li> </ol>	Recommended October 2012.

## Use of force training and tactics

No.	Finding/Issue	Recommendation and Implementation Steps	Status
26	The LVMPD needs to train every police and corrections officer on the new Use of Force Policy.	LVMPD should implement a program that trains all police and corrections officers on the reformed Use of Force Policy. LVMPD mandated every police and corrections officer attend a four-hour training class focused on the revisions made to the Use of Force Policy. The training was conducted over a 5-week period and covered every change to the policy, with an emphasis on: <ul style="list-style-type: none"> <li>• The sanctity of human life</li> <li>• De-escalation of force</li> <li>• Force transition</li> <li>• New intermediate level of force</li> <li>• Major revisions made to weapons (rifle, ECD, and less-lethal shotgun)</li> </ul>	As of June 30, 2012, approximately 2,700 employees have completed this training.
27	The LVMPD needed to revise its use of force training based on analysis of the department's trends.	LVMPD should implement a training program that is based on the analysis of the department's trends. The LVMPD implemented the revised Advanced Officer Skills Training (AOST) program. AOST is a mandatory eight-hour class given once a year to all patrol officers. This training is both classroom and scenario based. An adjustment in AOST curriculum was made when CIRT began to identify training and tactical needs of the agency, based on their internal review process. Some of the areas of training specifically impacted by CIRT are: <ul style="list-style-type: none"> <li>• Use of less-lethal options (2011)</li> <li>• Foot pursuit training (2011)</li> <li>• Scenarios based on the principal of de-escalation (2011 &amp; 2012)</li> <li>• Police on Police encounters (2011)</li> <li>• Situational Awareness and in-custody calls/Search and Seizure (2012)</li> </ul>	Ongoing since January 2011.

No.	Finding/Issue	Recommendation and Implementation Steps	Status
28	<p>LVMPD's evaluation of the most recent Use of Force Policy training suggests that officers have the most trouble comprehending policy in the context of a written scenario. Approximately 20 percent of officers were unable to accurately describe a subject's level of resistance and the appropriate level of control to use. Approximately 12 percent of officers were unable to accurately identify the basis for an authorized use of ECD on a fleeing suspect.</p>	<p>LVMPD should take the appropriate steps to understand whether the failed test questions were problematic due to the clarity of the question or to officers' lack of comprehension. LVMPD should hold focus groups with officers who answered the questions correctly and those who answered incorrectly, in order to discern the relevant causes of incorrect answers. The focus group facilitator should seek to understand: whether the questions were worded clearly; whether the officers had received the information during training; and whether officers simply had trouble with any concepts or the way they should be applied in scenarios. LVMPD should also take this opportunity to retrain the officers in the new ECD policy and the force model.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Identify officers who failed to correctly answer scenario-based questions on the Use of Force Policy exam.</li> <li>2. Select a facilitator for focus groups.</li> <li>3. Schedule a series of focus groups with randomly selected officers:</li> <li>4. If it is discovered that officers had trouble with the concepts, then actions should be taken to address the problem, such as issuing bulletins, memos, and other appropriate means of communication throughout the department reinforcing the concepts and their proper application.</li> <li>5. If it is learned through the focus groups that the test questions and answers were insufficient or unclear in some way, revise the test as needed.</li> </ol>	<p>Recommended October 2012.</p>
29	<p>The LVMPD needed to create more realistic use of force training to better prepare officers to handle dynamic situations and to successfully bring them to the best conclusion.</p>	<p>LVMPD should implement a Reality-Based Training (RBT) program. RBT was implemented in October 2011. The RBT program is a mandatory semi-annual squad training program for all Patrol, Community-Oriented Policing (COP), and Problem Solving Unit (PSU) Sergeants and Officers. RBT consists of three blocks of training: Knowledge Based Training (classroom), Advanced Defensive Tactics, and Reality-Based Training (Scenarios). RBT focuses on teaching squads to work together to handle dynamic situations and to successfully bring them to the best conclusion. RBT provides relevant training on lessons learned through classroom instruction, along with scenario training. Scenario training incorporates the use of department buildings, Simunitions and role players. With the training being mandated twice a year, it can address any emerging deficiencies or challenges that LVMPD was experiencing. This training is created and vetted in the same manner as AOST training.</p>	<p>Initiated in October 2011. Currently in process. Phase I has been completed. 611 commissioned officers have completed Phase II.</p>
30	<p>The LVMPD needed to focus on reality-based supervisory responsibility in its use of force training.</p>	<p>LVMPD should focus on reality-based supervisory responsibility in use of force training. For supervisors, Reality-Based Training (RBT) was designed specifically with the emphasis placed on leadership during team scenarios. Supervisors go through each scenario prior to taking their officers through the training. With this structure, supervisors are scheduled to go through the training four times a year.</p>	<p>Initiated in October 2011. Currently in process.</p>

No.	Finding/Issue	Recommendation and Implementation Steps	Status
31	LVMPD's new Reality-Based Training program is essential to the department's efforts to continue to improve officers' tactics and prepare them for various real-life encounters. However, scheduling conflicts have hampered the program's full implementation.	<p>LVMPD should proceed with the current schedule of RBT and conduct a manpower study in order to ensure that it can accommodate the completion of twice yearly RBT training.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Convene an internal group of analysts, trainers, and command staff, including management analysts, to complete staffing assessment regarding RBT.</li> <li>2. Conduct manpower study. The study should:               <ol style="list-style-type: none"> <li>a. Determine the number of RBT trainers needed to maintain the program's semi-annual requirement</li> <li>b. Define the appropriate staffing level and/or schedule</li> <li>c. Determine changes in scheduling that would need to occur</li> <li>d. Provide a range of options for meeting the RBT semi-annual goal</li> </ol> </li> </ol>	Recommended October 2012.
32	The LVMPD needed to focus on de-escalation in its use of force training.	<p>LVMPD should focus on de-escalation in use of force training. De-escalation has become a main focus in the LVMPD mandatory use of force training. Officers were specifically instructed to slow down the momentum of a call, get a supervisor to the scene, and consider their force options whenever feasible. They were instructed to continually reassess the threat presented based on the time they have to make decisions and the dynamics of the citizen contact. RBT and AOST scenarios continue to focus on de-escalation.</p>	Completed June 2012.
33	The LVMPD de-escalation training is not a requirement and does not include an evaluation component.	<p>LVMPD should establish an annual requirement for officers at the rank of sergeant and below to undergo a minimum number of hours of de-escalation training and formalize assessments of de-escalation tactics in AOST and RBT.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Review current de-escalation training provided in various courses, including number of combined hours currently provided.</li> <li>2. Determine which courses could be revised or extended to include increased and improved de-escalation training.</li> <li>3. Update lesson plans to include actual training of de-escalation techniques.</li> <li>4. Areas to be covered consistently and uniformly include:               <ol style="list-style-type: none"> <li>a. Effective communications</li> <li>b. Verbal commands</li> <li>c. Communications during passive resistance</li> <li>d. De-escalation techniques</li> <li>e. Risk/threat mitigation techniques</li> </ol> </li> </ol> <p>LVMPD should also devote one quarter of its defensive tactics training to de-escalation.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Update defensive tactics training manual to reflect new de-escalation requirement.</li> <li>2. Update policy manual to include new de-escalation component of annual defensive tactics training requirement.</li> </ol>	Recommended October 2012.

No.	Finding/Issue	Recommendation and Implementation Steps	Status
34	The LVMPD needed to focus on constitutional policing in its use of force training.	LVMPD should focus on constitutional policing in its use of force training. The LVMPD began focusing on constitutional policing topics. The LVMPD has written and produced short training videos for its officers on topics that include consensual stops and investigative detention/"Terry Stops." These videos are educational and focus on assisting officers in the process of making lawful decisions in the field (see Recommendation 8).	Completed July 2012. The first video was distributed department-wide May 22, 2012, the second on July 11, 2012.
35	The evaluation component of LVMPD's training programs is inadequate. The department does not focus on department-wide trends, which could highlight problem areas that need to be addressed more thoroughly.	LVMPD should develop a greater data collection and evaluation capacity for all training conducted throughout the department and should use that data to identify and proactively address any deficiencies. <b>Implementation steps:</b> 1. Determine IT needs for centralized training database. 2. Review and revise all training evaluation forms. 3. Assign staff as needed for management, analysis, and reporting functions with respect to training. 4. Update the policy manual as necessary to formalize the new data collection process, analysis, and reporting functions.	Recommended October 2012.
36	The LVMPD needed to recertify its Crisis Intervention Team officers who interact with persons suffering from mental illness.	LVMPD should develop and implement a Crisis Intervention Team (CIT) Recertification Program. CIT officers interact with persons suffering from mental illness, some of whose behavior could be met with force. The LVMPD implemented a program that trains up to 400 officers per year. LVMPD will now recertify all CIT officers on a three-year basis. The department has also made CIT certification a preferred skill for advancement in the organization.	Initiated in August 2012. Currently in process.
37	LVMPD's Crisis Intervention Team recertification program does not contain sufficient frequency or number of hours.	LVMPD should update its training policies to reflect the Crisis Intervention Team (CIT) recertification requirement and increase its number of hours and frequency. <b>Implementation steps:</b> 1. Identify the time and resources needed to modify the CIT recertification requirement to be longer and more frequent. 2. Review LVMPD CIT responses and reports in order to identify training needs and update training as necessary. 3. Consider conducting site visits to other agencies that have well-established mental health programs in order to learn about best practices and incorporate those into LVMPD training.	Recommended October 2012.



No.	Finding/Issue	Recommendation and Implementation Steps	Status
38	Defensive tactics training in LVMPD lacks consistency in terms of quality and quantity throughout the department.	<p>LVMPD should exercise the necessary oversight and control to ensure consistency through a policy of instructor audits.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Increase the number of trainers in the Training Bureau to provide sufficient staff for an auditing component.</li> <li>2. Develop a process to assign trainers on a rotating basis to conduct unannounced audits of defensive tactics training.</li> <li>3. Auditing should include the following:               <ol style="list-style-type: none"> <li>a. Unannounced attendance at training</li> <li>b. Review of attendance list</li> <li>c. Review of lesson plan and attendance list for past sessions</li> </ol> </li> <li>4. Develop and provide an auditing checklist/form for auditors, to include:               <ol style="list-style-type: none"> <li>a. Name of trainer</li> <li>b. Topics covered</li> <li>c. Length of training</li> <li>d. Type of training (e.g., scenario-based and classroom)</li> <li>e. Review of lesson plan for content</li> <li>f. Handouts provided during training if applicable</li> <li>g. Handouts should be collected and reviewed by auditor to ensure they are consistent with department policy and standards</li> <li>h. Training attendance, including:                   <ol style="list-style-type: none"> <li>i. Number of attendees, ranks, assignments</li> <li>ii. List of scheduled attendees</li> </ol> </li> </ol> </li> <li>5. Auditors should identify absentees and whether their absence was excused and rescheduled.</li> <li>6. Quarterly reports should be prepared that document a summary of audit results and any recommendations for improvement. The report should be distributed to all bureau/area commands.</li> <li>7. An annual summary of audits should be produced and reported to executive/ command staff.</li> </ol>	Recommended October 2012.
39	The LVMPD needed to implement an individualized training program for officers involved in deadly force situations who committed policy, procedural, or tactical errors.	<p>LVMPD should implement an individualized training program for officers involved in deadly force situations when there were errors. Based on errors identified by the CIRT or Use of Force Review Board (UoFRB), the LVMPD now conducts individualized training for these officers.</p>	Completed October 2010.

No.	Finding/Issue	Recommendation and Implementation Steps	Status
40	The LVMPD needs to better manage multiple officer situations. Tactical errors and fatalities are more prevalent when multiple officers are on the scene.	<p>LVMPD should ensure that supervisors and officers are prepared to handle multiple officer situations in the context of deadly force. It should use reality-based incident command scenarios to train supervisors and officers on the management and direction of multiple officers during a critical incident.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Design a scenario that accounts for procedures as outlined in LVMPD Policy Manual, Major Incident and All Hazard Plan.</li> <li>2. Develop and implement training for supervisors and officers that addresses the management and direction of multiple police officers during a critical incident.</li> <li>3. Develop separate evaluation guides for assessing supervisor and officer training performance.</li> <li>4. Identify scheduling and staffing needs to implement reality-based incident command training.</li> <li>5. Educate workforce on new training requirements.</li> </ol>	Recommended October 2012.
41	The LVMPD is unable to determine whether officer training requirements are being properly monitored by the Bureau Training Coordinator program.	<p>LVMPD should follow existing policy and audit the Bureau Training Coordinator program to ensure that it is accurately monitoring and tracking completion of training requirements.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Design an auditing process for the program. The audit should include: <ol style="list-style-type: none"> <li>a. Interviews with training coordinators, line officers, and supervisors</li> <li>b. Analysis of training compliance by area command/bureau</li> <li>c. Review of monthly training reports and any other standardized reports that training coordinators are responsible for submitting to commanders</li> </ol> </li> <li>2. Produce a report on audit findings that highlights strengths and weaknesses and provides recommendations for improving the program.</li> <li>3. Disseminate findings to executive staff, supervisors, training coordinators, and line officers.</li> <li>4. Establish a process for changing the bureau training coordinator program as needed.</li> <li>5. Consider designing a new system for monitoring the completion of training requirements that includes dedicated personnel.</li> </ol> <p>In addition, LVMPD should update its training database to accurately reflect officer rank and update its archiving process to include this information for all future years.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Identify promotion years of all officers.</li> <li>2. Update training archives, so that officer rank for each year is accurate.</li> <li>3. Update internal system to capture officer rank at the current time when updating training completion.</li> <li>4. Establish a policy to track when officers are promoted or have new assignments that will affect their training requirements.</li> </ol>	Recommended October 2012.

**COLLABORATIVE REFORM MODEL**

A Review of Officer-Involved Shootings in the Las Vegas Metropolitan Police Department

No.	Finding/Issue	Recommendation and Implementation Steps	Status
42	The LVMPD needed to enhance officer safety through lessons learned in previous incidents.	LVMPD should develop a method to enhance officer safety through lessons learned from previous incidents. LVMPD developed a series of OIS reenactment videos. CIRT produced the first video reenactment of an OIS and disseminated it for department-wide training and used it as an ongoing training tool.	Initial Video Completed March 2011. Ongoing.
43	The LVMPD video-based interactive decision-making training program (MILO) needed to be expanded to include in-service training.	LVMPD should implement video-based decision-making training for veteran as well as newly hired officers. LVMPD recognized that although new recruits in the Academy had access to video-based decision-making training, veteran police officers had not attended such training in several years. All police officers now are required to attend interactive training annually.	Completed October 2011.
44	The LVMPD needed to ensure that its supervisors were trained on the new Use of Force Policy.	LVMPD should train all supervisors on the new Use of Force Policy prior to the training of their officers. All supervisors are mandated to attend a Use of Force Policy training to review any updates to the policy and/or training.	Completed June 2012. Ongoing.
45	The LVMPD needed to expand mandatory Electronic Control Device (ECD) training (e.g., Tasers).	LVMPD should expand Mandatory ECD Training beyond two hours. As of March 2012, LVMPD requires every police officer who carries an ECD to attend a four-hour mandatory training class. The class includes inspection of each officer's ECD, classroom lecture, and scenario-based training.	Completed March 2012.
46	The LVMPD did not have an Electronic Control Device (ECD) inspection process.	LVMPD should implement a mandatory ECD inspection program. LVMPD discovered it had no formal process of inspection for the weapon and there was no consistent mandatory/hands-on annual training with the ECD. LVMPD has now dedicated a fulltime officer to ECD inspections/training.	Completed October 2010.
47	Some LVMPD instructors did not express support for portions of the Use of Force policy reforms during training.	<p>LVMPD instructors should express support for new policies. When illustrating policy violations, they should take the opportunity to explain that they are not only potentially illegal, but that they do not represent the best in policing or reflect the values of the police department. This should be ensured through instructor training and audits of instruction conducted throughout the department.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Ensure instructor support through instructor training and audits. Audit should include:               <ol style="list-style-type: none"> <li>a. Evaluation of the professionalism, behavior, and attitude of the in-house instructor</li> <li>b. Evaluation of the perceived receptiveness, attitude, behavior, and response of the trainees</li> </ol> </li> <li>2. OIO or training bureau supervisors should use audits to make recommendations for any changes, additional training, or corrective action based on the audits.</li> <li>3. Consideration should be given to removing in-house instructors from training assignments who consistently demonstrate a disdain or lack of support for policies and procedures of the LVMPD.</li> <li>4. Engage police associations, human resources, command staff, and legal counsel to develop a fair but effective process to correct behavior or remove in-house instructors if they are deemed unprofessional or inappropriate.</li> </ol>	Recommended October 2012.

No.	Finding/Issue	Recommendation and Implementation Steps	Status
48	LVMPD needed to enhance officer safety when police encounter other officers in plainclothes.	LVMPD should implement Police-on-Police Training. LVMPD established a mandatory in-service training class titled, "Police-on-Police Encounters," for all Problem Solving Units (PSU). PSU are plainclothes officers working in substations.	Completed March 2011.
49	LVMPD needed unit-specific training that addresses OIS incidents.	LVMPD should develop specialized training for units in response to OISs handled improperly. As a result of a critical incident involving a narcotics squad, CIRT initiated specialized unit-based training in critical incident response.	Completed March 2011.
50	The LVMPD needed a training module that focused on weapons and flashlights.	LVMPD should implement a training module that focuses on weapons and flashlights. The LVMPD focused on their combined training after a review of a critical incident in January 2011. The LVMPD CIRT identified that there was only sporadic training being conducted that addressed the tools combined use. In November 2011, the LVMPD Range began including flashlight techniques as part of the quarterly qualifications.	Completed November 2011.
51	Actual LVMPD radios are seldom used in LVMPD scenario-based training. However, in our review of OIS incidents, the most frequent tactical error involved radio communication.	<p>In all scenario-based training, trainees should be using actual LVMPD radios to enhance the experience and make it as realistic as possible.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Develop a procedure for regularly using live communications and radio use during scenario and interactive training.</li> <li>2. Procedure should include the following: <ol style="list-style-type: none"> <li>a. Reserving tactical frequency for the anticipated training period</li> <li>b. Notifying dispatch that training is being conducted</li> <li>c. Assigning a dispatcher to perform the function of the on-duty dispatcher for the training session</li> </ol> </li> <li>3. Direct trainees to include radio communications in their response to scenarios as if it were a real-world event.</li> <li>4. Include use of radio in trainee debriefing.</li> <li>5. Modify training as needed based on instructor observations and lessons learned from prior training sessions.</li> </ol>	Recommended October 2012.
52	The LVMPD Policy Manual has not been updated to reflect current AOST requirements.	<p>As a result of recent reforms, LVMPD should update its policy manual to reflect the actual Advanced Officer Skills Training (AOST) program.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Review current practice of AOST and update the policy manual to describe it accurately.</li> <li>2. Distribute policy changes and notify personnel through the appropriate LVMPD distribution process, roll call announcements, bulletins, and the training coordinator's scheduling procedures.</li> </ol>	Recommended October 2012.

## Use of force investigation and documentation

No.	Finding/Issue	Recommendation and Implementation Steps	Status
53	The LVMPD needed to establish the capacity to conduct comprehensive deadly force reviews that are administrative in nature.	LVMPD should conduct comprehensive administrative deadly force investigations. The LVMPD developed the Critical Incident Review Team (CIRT). CIRT conducts in-depth reviews of all use of deadly force incidents. CIRT investigations are administrative in nature. The statements and evidence obtained are for internal use only, and are used to dissect the officer’s tactics, decision making, and training. The information is then used to affect training given department wide. In addition, CIRT now presents their incident reviews to the Use of Force Review Board. (See Recommendation 3.)	Completed July 2010.
54	The LVMPD developed a Force Investigation Team (FIT) model in late 2010. In April 2012, citing manpower issues, the Robbery and Homicide Division stopped the FIT model of one squad handling all officer-involved uses of deadly force. They returned to a process of all Homicide squads handling the investigations on a rotating basis.	<p>LVMPD should re-establish a specialized group of investigators designated to conduct comprehensive deadly force investigations, in conjunction with the District Attorney’s Office, that are legal in nature.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Review staffing requirements to ensure a sustainable model.</li> <li>2. Select officers to participate.</li> </ol> <p>Formalize training requirements for all officers who conduct investigations.</p>	Recommended October 2012.

No.	Finding/Issue	Recommendation and Implementation Steps	Status
55	The LVMPD needed to develop more specific use of force finding categories in order to provide greater accountability.	<p>LVMPD should develop more specific use of force finding categories in order to provide greater accountability. The LVMPD implemented new Use of Force Review Board (UoFRB) determinations. The findings were significantly revised from simply Justified or Not Justified to the following:</p> <ul style="list-style-type: none"> <li>• <b>Administrative approval:</b> No recommendations. Objectively reasonable force was used under the circumstances based on the information available to the officer at the time. This finding acknowledges that the use of force was justified and within LVMPD policy. There are no concerns surrounding the tactics employed, and there are no policy violations including those not relating to the application of force.</li> <li>• <b>Tactics/Decision making:</b> This finding considers that the tactics and/or decision making employed were less than satisfactory. Specifically designed training will be prescribed to address deficiencies.</li> <li>• <b>Policy violation not directly related to use of force:</b> This finding covers a range of policy violations including failure to qualify with a firearm, use of unauthorized ammunition, failure to carry required equipment, etc. A policy violation was identified but was not connected to the use of force.</li> <li>• <b>Policy/training failure:</b> An outcome was undesirable but did not stem from a violation of policy or failure to follow current training protocols. An LVMPD policy and/or specific training protocol is inadequate, ineffective, or deficient; the officer followed existing policy and/or training, or there is no existing policy and/or training protocols that address the action taken or performance demonstrated. This finding reflects global policy or training deficiencies.</li> <li>• <b>Administrative disapproval:</b> The UoFRB has concluded through this finding that the force used or action taken was not justified under the circumstances and violated LVMPD policy. This outcome is reserved for the most serious failures in adherence to policy, decision making, and/or performance.</li> </ul>	Completed June 2012.

No.	Finding/Issues	Recommendation and Implementation Steps	Status
56	<p>In the past, the Use of Force Review Board rarely issued disciplinary or corrective action, due to both structural constraints and a lack of institutional oversight.</p>	<p>LVMPD should formalize the new functions of the UoFRB in its policy manual and monitor their continued implementation and impact. As this process continues to mature and is formalized into departmental policy, it will allow the department to identify gaps in training, policy, and tactics. In addition, the department should review the level of implementation closely as the new process is standardized.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Formalize the new functions of the UoFRB in the LVMPD Policy Manual. These new functions should include the following:               <ol style="list-style-type: none"> <li>a. The new determinations (administrative approval; tactics/decision making; policy violation not directly related to the use of force; policy/training failure; and administrative disapproval)</li> <li>b. The expanded scope of the board that now allows it to review more than just the moment in which force is used</li> <li>c. The assignment of an assistant sheriff as the chairman of the board</li> <li>d. The authority of the UoFRB to now issue discipline</li> </ol> </li> <li>2. Have OIO provide officers with an overview of the updated policy in a bulletin, roll call, or similar format.</li> </ol>	<p>Recommended October 2012.</p>

No.	Finding/Issues	Recommendation and Implementation Steps	Status
57	LVMPD standard operating procedures for the Use of Force Review Board are outdated and insufficient.	<p>LVMPD should develop a stand-alone manual for its UoFRB containing standard operating procedures, the roles and responsibilities of involved parties, and the purpose of the board.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Consider reformulating the structure and operations of the UoFRB, based on recommendations and findings.</li> <li>2. Formalize the roles and responsibilities for each member of the UoFRB in the LVMPD Policy Manual.</li> <li>3. OIO will announce the updated policy in a bulletin, roll call, or similar format to all the officers in the department.</li> <li>4. OIO and ODB will conduct a training session for all commissioned UoFRB members and civilian members on the new manual.</li> </ol> <p>LVMPD should also reassess how citizen board members are selected to participate in the Use of Force Review Board process.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Identify potential citizen participants</li> <li>2. Engage with, solicit and encourage feedback and input from the executive command, public interest groups, community stakeholders, police associations, and legal counsel</li> <li>3. Engage with, solicit and encourage feedback and input from current UoFRB citizen members <ol style="list-style-type: none"> <li>a. Citizen members currently serving on the board will be grandfathered into the new process until their term is complete</li> </ol> </li> <li>4. Formalize the new Use of Force Review Board citizen member selection process in the LVMPD Policy Manual</li> <li>5. Announce the new selection process to the members of the board (commissioned and citizen) in a bulletin, roll call/memo, or similar format</li> <li>6. Make public the new process through a variety of media</li> </ol>	Recommended October 2012.
58	Presentations by LVMPD personnel to the Use of Force Review Board, as well as questions by members of the UoFRB, are not perceived as objective.	<p>LVMPD should mitigate the potential for bias and leading questions, and emphasize the UoFRB's objectivity by providing members of the board and presenters with training on how to present information and/or ask questions in a non-biased or neutral fashion.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Formalize this new training requirement in the LVMPD Policy Manual.</li> <li>2. Announce this new training requirement to the members of the board (commissioned and citizen) in a bulletin, roll call/memo, or similar format.</li> <li>3. Provide members of the board and presenters with mediation training.</li> <li>4. Conduct audits of the training to ensure it is appropriately and consistently presented.</li> <li>5. Solicit evaluations of the training from the attendees and modify as needed.</li> <li>6. Monitor the results of the training, by observing UoFRB, to determine whether it has achieved the desired result of reducing the appearance of bias.</li> </ol>	Recommended October 2012.



No.	Finding/Issues	Recommendation and Implementation Steps	Status
59	LVMPD's process for tracking the implementation of UoFRB recommendations is informal and unrefined.	<p>LVMPD should streamline the exchange of information between OIO and bureau commanders who are in charge of ensuring that UoFRB recommendations are implemented.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Revise the current Informal Training Accountability Protocol (ITAP) process to reflect the new process for exchange of information with respect to implementing UoFRB recommendations.</li> <li>2. Brief appropriate parties on the new roles and responsibilities and the new process.</li> <li>3. Include a timeline for the completion of recommendations.</li> <li>4. Include a requirement to conduct regular audits to ensure compliance with the ITAP.</li> </ol> <p>In addition, LVMPD should update its policy manual to include the Informal Training Accountability Protocol (ITAP) and formalize the process.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Finalize the ITAP process in written format.</li> <li>2. Have internal reviewers provide feedback on the process and make adjustments as necessary.</li> <li>3. Educate the workforce on the new process and policy through first-line supervisors and a department-wide bulletin.</li> </ol>	Recommended October 2012.
60	LVMPD does not analyze use of force reporting and data on a routine basis in order to identify department-wide trends and quickly remedy any issues.	<p>LVMPD should analyze use of force reporting and data on a regular basis in order to identify trends and quickly remedy any issues through remedial training or discipline if needed.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Update LVMPD Policy Manual to reflect new analysis and quality assurance functions with respect to use of force statistics.</li> <li>2. Identify personnel needs to fulfill new function.</li> <li>3. Monitor progress of new function and update process as appropriate.</li> </ol>	Recommended October 2012.

No.	Finding/Issues	Recommendation and Implementation Steps	Status
61	The LVMPD does not conduct a comprehensive review of an officer's training record as part of its administrative use of force investigations.	<p>As part of its standard use of force investigations, the LVMPD should conduct a comprehensive review of an officer's training record, to include historical data on training requirements and remedial training.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Identify training requirements that align with common tactical and policy issues arising from OISs.</li> <li>2. Design a standard request form for training records for officers involved in a shooting, to include the following:               <ol style="list-style-type: none"> <li>a. All optional and mandatory training courses</li> <li>b. Remedial training</li> <li>c. Timeframe of training request (i.e., in the previous two years, three years, or more)</li> <li>d. Trainer evaluations for each specified training course</li> </ol> </li> <li>3. Update the CIRT Administrative Report template to reflect new training review.</li> <li>4. Provide CIRT investigators and staff with an overview of the new standard for training reviews in a bulletin, briefing, or similar format.</li> <li>5. Provide necessary personnel resources to achieve this recommendation.</li> </ol>	Recommended October 2012.
62	LVMPD homicide investigators do not consistently video-record all interviews for officer-involved shootings.	<p>As part of their investigatory and interview procedures in an OIS, homicide investigators should video and audio record all interviews with the involved officers and, when appropriate, witnesses.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Formalize procedures of video-recording all interviews as part of the investigation of a deadly force incident in the LVMPD Policy Manual.</li> <li>2. The Homicide and Robbery Division and ODB will conduct training on the updated policy and/or provide officers with an overview of the updated policy in a bulletin, roll call, or similar format.</li> </ol>	Recommended October 2012.
63	The LVMPD needed to create a mechanism to provide its workforce with timely information following a deadly-force incident.	<p>LVMPD should provide personnel with timely awareness of issues that arise following a deadly-force incident. Since February 2011, the LVMPD has authored and distributed an Awareness Report. The Awareness Report is a brief, preliminary report that provides the workforce with a general, factual summary of events as known to the department. It references any policies, protocols, and/or training doctrines related to the critical incident. CIRT continues to author and distribute an Awareness Report within 24-48 hours after a critical incident.</p>	Completed February 2011.

No.	Finding/Issues	Recommendation and Implementation Steps	Status
64	The Police Protective Association and Police Managers and Supervisors Association have directed their members to not cooperate in deadly force investigations if involved in an OIS.	<p>In order to ensure complete and thorough investigations and engender community trust, the police associations should encourage their officers who are involved in shootings (i.e., shooters, witness officers, and supervisors) to fully cooperate with the OIS investigations.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Engage police associations in a dialogue about officers giving interviews in the event of an OIS.</li> <li>2. Establish protocols that respect officer constitutional rights as it relates to self-incrimination.</li> </ol>	Recommended October 2012.
65	LVMPD needed to compile and maintain detailed deadly force statistics that can be used to identify trends and increase transparency.	<p>LVMPD should compile and maintain detailed deadly force statistics that can be used to identify trends and increase transparency. The LVMPD Office of Internal Oversight uses this data to inform an internal Quarterly Report detailing progress made toward meeting LVMPD’s mission of significantly reducing deadly force incidents.</p>	Completed August 2012.
66	LVMPD has produced an annual review of OIS statistics and plans to disseminate the report to the public.	<p>LVMPD should formalize the production and dissemination of an annual report of OIS statistics.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Formalize the procedures for producing and publishing the annual OIS statistical report in the LVMPD Manual.</li> <li>2. Use the annual reports to analyze trends and identify gaps.</li> <li>3. Disseminate this report both internally and externally in a timely manner.</li> </ol>	Recommended October 2012.
67	LVMPD’s administrative use of force reporting process does not include review and input from key administrative components.	<p>LVMPD should formalize a peer review of its administrative use of force investigation reports. Prior to the presentation to the Use of Force Review Board, the report should be validated for accuracy and completeness by the Internal Affairs Bureau, the Training Bureau, Quality Assurance, and legal counsel.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Identify LVMPD components that are frequently impacted by CIRT investigative findings and recommendations (i.e., Training, Internal Affairs, Quality Assurance, Policy and Research, and legal counsel).</li> <li>2. Recruit peer reviewers from these components.</li> <li>3. Brief peer reviewers on their role and responsibilities. The roles and responsibilities include:               <ol style="list-style-type: none"> <li>a. Identifying substantive issues surrounding the incident</li> <li>b. Providing input on any recommendation</li> </ol> </li> <li>4. Update CIRT Section Manual to include the peer review role.</li> </ol>	Recommended October 2012

## Use of force incident review

No.	Finding/Issue	Recommendation and Implementation Steps	Status
68	The Coroner's Inquest process related to review of deadly force incidents is ineffective.	<p>The Clark County Commission should review the necessity and purpose of the Coroner's Inquest since it is now being met by the public release of the DA's Memorandum of Decision and the LVMPD OIS review.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. The sheriff should continue to support and initiate organizational changes within the department that promote police accountability and public transparency.</li> </ol>	Recommended October 2012.
69	The Clark County District Attorney's Office needs more training and expertise related to investigating deadly force incidents.	<p>The Clark County DA's Office should acquire additional expertise and dedicate resources to investigate OISs more comprehensively.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Conduct a needs assessment to identify additional resources required for the investigation and review of all OISs and other significant uses of force.</li> <li>2. Develop protocols to help inform the DA's role in investigating shootings in cooperation with LVMPD, and the subsequent review and issuance of findings.</li> </ol>	Recommended October 2012.
70	The Clark County District Attorney has begun to review officer-involved shootings that result in death and to issue decision letters regarding criminal findings. However, decision letters are not issued for serious, non-fatal use of force incidents.	<p>The Clark County District Attorney's Office should continue to review all fatal use of force cases and should also review significant uses of force that did not result in death.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. The DA's office should review existing statutes, policies, and procedures to determine requirements for mandatory reviews of OISs and other significant uses of force, including those not resulting in death.</li> <li>2. After conducting this review, the DA should meet with the sheriff to discuss changes to its review process of OISs.</li> </ol>	Recommended October 2012.

## Community perspectives and outreach

No.	Finding/Issue	Recommendation and Implementation Steps	Status
71	The LVMPD is now releasing deadly force investigation summary reports in response to community concerns about the perceived lack of accountability for officers involved in OISs.	<p>LVMPD should provide greater transparency of its police operations and internal reviews relating to use of deadly force by creating a policy to mandate the timely release of information on OISs and more open dialogue with the public.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Formalize the procedures for the public release of information following an OIS in the LVMPD Policy Manual.</li> <li>2. Engage with LVMPD police officer associations to consider employee concerns and ensure that the procedures do not compromise officer privacy and safety.</li> <li>3. OIO and Public Information Officer (PIO) will provide officers with an overview of the updated policy and procedures in a bulletin, roll call, or similar format.</li> </ol>	Recommended October 2012.
72	LVMPD needed to increase transparency related to deadly force incidents.	<p>LVMPD should implement a protocol to release documents related to Deadly Force incidents. The LVMPD Office of Internal Oversight (OIO) began releasing documents related to OISs in conjunction with the decision letters released by the District Attorney's office. The redacted homicide report and the OIO Review are now released. These documents are posted on the LVMPD website along with the DA letters:</p> <ul style="list-style-type: none"> <li>• <b>Homicide Report:</b> The report contains evidence found by the investigating Homicide detectives. These reports will be made available in their entirety on the LVMPD OIO webpage. Information deemed confidential in nature will be redacted.</li> <li>• <b>OIO Review:</b> This review includes the findings of the Use of Force Review Board and will also include any changes or additions made to policy, procedure, tactics, or training if found necessary to do so as a result of a deadly force incident.</li> </ul>	Initiated in June 2012. Ongoing.
73	LVMPD currently lacks standards and procedures for releasing information on OISs to the media and the public.	<p>LVMPD should develop a formal communications/media strategy for OISs.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Formally draft a communications/media strategy for deadly force incidents. This strategy document should be referenced in the LVMPD policy, but should also serve as a stand-alone reference document.</li> <li>2. The Public Information Office (PIO), in collaboration with the OIO, should develop and provide notifications on this new communications strategy to its officers via roll call and/or bulletins.</li> </ol>	Recommended October 2012.

No.	Finding/Issue	Recommendation and Implementation Steps	Status
74	The information LVMPD provides to the public on the circumstances of OISs is not meeting community expectations and is contributing to the public's negative perception of LVMPD.	<p>LVMPD should work with community leaders and other stakeholders to establish mutual expectations and a process for the release of information to the public following an OIS.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. LVMPD should partner with community leaders and other stakeholders as it implements the reforms described in this matrix.</li> <li>2. After incidents involving deadly force, Executive Command and Area Commanders should instruct a designated LVMPD representative to:               <ol style="list-style-type: none"> <li>a. Attend community meetings to clarify misconceptions about police actions, dispel rumors, and provide community members with accurate information regarding the incident</li> <li>b. Meet with local community stakeholders regarding their concerns and reiterate the actions the police department is taking to hold police accountable</li> <li>c. Host town hall meetings and provide residents with information on the case (as it is appropriate for release) and discuss what the department is doing to investigate the incident fully in order to ensure that any officer(s) found to have violated policy and/or procedure will be held accountable</li> <li>d. Brief key community leaders to assist with and support officer/command presentations (within the law and considering the integrity of the investigation and privacy)</li> </ol> </li> <li>3. Distribute the press releases of the incident to local community members who have expressed concern over the incident.</li> <li>4. Formalize the above procedures in the LVMPD Policy Manual.</li> <li>5. OIO and ODB will conduct training on this new policy and procedure and/or provide designated LVMPD representatives with an overview of the updated policy in a bulletin, roll call, or similar format.</li> </ol>	Recommended October 2012.
75	The LVMPD Sherman Gardens community policing model has proven effective at enhancing police-community partnerships within that neighborhood.	<p>LVMPD should develop community policing strategies similar to those used in Sherman Gardens and apply them to other high crime neighborhoods in an effort to enhance police-community partnerships across the city.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Convene a planning team to identify and transition core community policing principles. Consider replicating successful initiatives, such as the one deployed in Sherman Gardens, in other Las Vegas communities.</li> <li>2. Identify other location(s) for implementing and/or replicating community policing initiatives.</li> </ol>	Recommended October 2012.

No.	Finding/Issue	Recommendation and Implementation Steps	Status
76	LVMPD has publically expressed its commitment to providing officers with wearable cameras.	<p>Wearable camera technology is relatively new, and further research is still needed regarding its efficacy. LVMPD has invested in this innovative technology and should collect operational data and evaluate its effectiveness in the field. Lessons learned from this pilot will not only benefit LVMPD and its community, but should also be shared with departments across the country to help inform their decisions to invest in this technology.</p> <p><b>Implementation steps:</b></p> <ol style="list-style-type: none"> <li>1. Executive Command should designate a team within ODB to coordinate and pilot the experiment. This team should:               <ol style="list-style-type: none"> <li>a. Review and meet with other departments that have piloted wearable cameras</li> <li>b. Identify lessons learned from these departments and incorporate into the planning and implementation process</li> <li>c. Conduct an assessment of available technology and determine an appropriate vendor for the equipment</li> <li>d. Consult with stakeholders, such as police officers, executive command, legal advisors, police associations, and community stakeholders</li> <li>e. Establish a timeframe for the pilot program</li> <li>f. Establish the goals and objectives of this pilot program. These goals and objectives can include:                   <ol style="list-style-type: none"> <li>i. Lowering the number of citizen complaints</li> <li>ii. Increasing public transparency</li> <li>iii. Increasing positive interactions among the police and their communities</li> <li>iv. Increasing police accountability</li> <li>v. Defending police against false complaints</li> <li>vi. Providing training lessons</li> <li>vii. Development of policy and procedures</li> </ol> </li> <li>g. Draft the policies and procedures that officers should follow when using the wearable cameras, including the following:                   <ol style="list-style-type: none"> <li>i. Process for retaining/archiving the recordings and chain of custody issues</li> <li>ii. Whether and when to use the camera</li> <li>iii. Use of personally-owned wearable cameras</li> <li>iv. Train officers on the policies and procedures of using the wearable cameras.</li> </ol> </li> <li>h. Train supervisors on the policies and procedures of using the wearable cameras to ensure the proper use of the cameras by their officers.                   <ol style="list-style-type: none"> <li>i. Review and analyze the data for trends on a quarterly basis.</li> <li>j. Deliver reports on this analysis to executive command on a quarterly basis.</li> <li>k. Confer with executive command and decide whether to discontinue the pilot or formally implement wearable cameras into the department.</li> <li>l. Release the analytical findings of the pilot program and the executive command’s decision to the department and public.</li> </ol> </li> </ol> </li> </ol>	Recommended October 2012.

# Appendix B: Sample Interview Checklist

## Interview outline \ checklist

Witness and involved officer interviews related to use of deadly force and in-custody death investigations

### I. Officers Background

Training and experience     Prior law enforcement     Prior Military experience  
 Other employment

Basic Academy	Y / N
Advanced academy	Y / N
In-Service Training	Y / N
Active Shooter	Y / N
Street Survival	Y / N
AR-15	Y / N
Less Lethal Shotgun	Y / N
Taser	Y / N
CIT	Y / N

Involvement in any other deadly force encounters  
 Current Assignment     Shift     Days off

### II. Physical / Mental State of Involved Officer

Generally how was the officer feeling that day?  
 Illnesses?  
 Amount of sleep?  
 Normal amount of sleep?  
 Use of any medication (prescription and non-prescription)  
 Use of Narcotics or other intoxicants  
 Use of Alcohol  
 Any arguments or disagreements with spouse, child, supervisor, partner, etc.?  
 Any other factors that may have affected the officers mental state

### III. Officers Activity Prior to the Incident

Tell about the 24 hour period prior to the event  
 Activity the night prior to the event (Movies, TV, Party etc)  
 Trip to work  
 Activity prior to work (Court, Workout, Golf, Sleep etc.)  
 Work activity prior to incident? (Number and Type of calls)

### IV. Prior information the officer had

Did the officer have any prior contacts with the involved subject?  
 Had the officer been on any prior calls to the location?  
 How familiar is the Officer with the geographic area?  
 Did the officer have any prior information about the individual or location?

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Police Assessment Resource Center  
 Portland Police Bureau: Officer-Involved Shootings and In-Custody Deaths (August 2005)  
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(roll call info, teletypes, radio broadcasts, MDT messages, other officers, TPS files).  
\_\_\_ Any other information that the officer had about the person or location

IV. Details of the incident.

\_\_\_ (obtain a diagram from officer depicting scene to include positions and locations)

\_\_\_ How did the officer get to the location? (code or not, route taken, speeds, traffic etc.)  
\_\_\_ Where/ how did the officer park and approach?  
\_\_\_ Was the vehicle used for cover? Describe  
\_\_\_ If traveling on foot describe route, running, walking, use of cover, and what objects were available for cover?  
\_\_\_ While travelling to location or making approach, were there conversations with partner (plans, tactics)  
\_\_\_ Radio transmissions while in route  
\_\_\_ What was the officers thought process while in route and approaching?  
\_\_\_ Describe the topography of the areas involved. (footing, obstacles, high ground, possible threats)  
\_\_\_ Describe the lighting at the location  
\_\_\_ What cover was available  
\_\_\_ Were you fully identified as law enforcement officers?  
\_\_\_ Were other officers present and where were they before, during and after the encounter?  
\_\_\_ Were there other witnesses or participants? What were they doing before during and after?  
  
\_\_\_ Describe in detail what was observed by you that made you take the actions you did.  
\_\_\_ Describe how the actions of the subject made you feel  
\_\_\_ What were you thinking during the encounter?  
\_\_\_ What was your thought process?

\_\_\_ What did you say and how did you say it.  
\_\_\_ What did other officers say?  
\_\_\_ What did the suspect say?  
\_\_\_ Did you hear anyone else (other suspects, witnesses)

\_\_\_ Describe when and why you drew your weapon.  
\_\_\_ Describe when and why you pointed your weapon at the suspect.  
\_\_\_ Describe your stance, grip, (flashlight in hand), cover.  
\_\_\_ Did you use your sights when you fired?  
\_\_\_ What was your point of aim?  
\_\_\_ What was your backdrop?  
\_\_\_ What do you think the distance was between you and the subject?  
\_\_\_ How many rounds do you think you fired? What sequence did you fire these rounds?  
\_\_\_ Do you know where your rounds impacted  
\_\_\_ What was the subject's reaction?  
\_\_\_ Did you reload? If so what did you do with the magazine you removed?  
\_\_\_ How is your weapon usually carried? Number of magazines, rounds?

\_\_\_ Were other force options available? What were they and why were they used or not used?

VI. Immediately after the encounter

\_\_\_ Describe your actions immediately after the encounter?  
\_\_\_ Did you approach the subject?  
\_\_\_ Who approached the subject?

- Was the subject handcuffed? Who did the handcuffing?
- When and why did you lower your weapon?
- When and why did you holster your weapon?
- Was the subject moved at all? How was the subject positioned?
- Was medical assistance requested and did they respond?
- What was broadcast on the radio?
- Who approached you and what was said or done?
  
- In hindsight do you think incident could have been approached in a way that presented less risk to yourself or others. How?
- Do you have any suggestions for improving relevant PPB training?
  
- Has anyone discussed the details of this case with you or have you learned information about the incident from sources other than your own observations?

VII. In-custody death investigations

- What contact did you have with the deceased?
- What contact did you observe others having with the deceased?
- What were your observations of the subject's physical condition prior to the subject being restrained?
- How was the deceased restrained and what tactics were used?
- How was the deceased positioned? Where was the deceased positioned, by whom, and for how long?
- Did you observe any injuries to the deceased?
- When did you notice the deceased was having medical problems?
- How did you and others respond to the medical problems?
- What is your training regarding the positioning of restrained persons?



## Resources

Below is a list of resources used in the creation of this report:

*“Deadly Force: When Las Vegas Police Shoot, and Kill,” Las Vegas Review Journal November 26, 2011*

*Deadly Force Statistical Analysis 2010–2011*, Las Vegas Metropolitan Police Department

*Office of Internal Oversight: Quarterly Report*, Las Vegas Metropolitan Police Department

*Petition Filed by the American Civil Liberties Union of Nevada and the National Association for the Advancement of Colored People, Las Vegas Chapter, to the Civil Rights Division*

*Proposed Revisions to the Las Vegas Metropolitan Police Department’s “Post Use of Force Policy,”*  
American Civil Liberties Union of Nevada

*“Use of Force Policy, June 2012,”* Las Vegas Metropolitan Police Department



## Glossary

<b>ACLU</b>	American Civil Liberties Union	<b>LVMPD</b>	Las Vegas Metropolitan Police Department
<b>ACLUNV</b>	American Civil Liberties Union of Nevada	<b>LVNR</b>	Lateral Vascular Neck Restraint
<b>ANSEC</b>	Analytical Section	<b>MPD</b>	District of Columbia's Metropolitan Police Department
<b>AOST</b>	Advanced Officer Skills Training	<b>NAACP</b>	National Association for the Advancement of Colored People
<b>CAD</b>	Computer Aided Dispatch	<b>OC</b>	Oleoresin Capsicum Spray (also known as Pepper Spray)
<b>CFS</b>	Call for Service	<b>ODB</b>	Organizational Development Bureau
<b>CIRP</b>	Critical Incident Review Panel	<b>OIO</b>	Office of Internal Oversight
<b>CIRT</b>	Critical Incident Review Team	<b>OIS</b>	Officer-Involved Shooting
<b>CIT</b>	Crisis Intervention Team	<b>PIO</b>	Public Information Officer
<b>COPS</b>	Office of Community Oriented Policing Services (the COPS Office)	<b>PMSA</b>	Police Managers and Supervisors Association
<b>CR-TAP</b>	Critical Response Technical Assistance Program	<b>PO</b>	Police Officer
<b>CSI</b>	Crime Scene Investigation	<b>POST</b>	Peace Officers' Standards and Training
<b>CTEPI</b>	Core Tactical Errors Per Incident	<b>PPA</b>	Police Protective Association
<b>DA</b>	District Attorney	<b>PPACE</b>	Police Protective Association for Civilian Employees
<b>DOJ</b>	U.S. Department of Justice	<b>PSU</b>	Problem Solving Unit
<b>DTI</b>	Defensive Tactics Instructors	<b>RBT</b>	Reality-Based Training
<b>ECD</b>	Electronic Control Device	<b>RJ</b>	Las Vegas Review Journal
<b>FID</b>	Force Investigation Division	<b>SWAT</b>	Special Weapons and Tactics Team
<b>FIT</b>	Force Investigation Team	<b>UMLV</b>	University of Metro Las Vegas
<b>FTTU</b>	Firearms Training and Tactics Unit	<b>UoFRB</b>	Use of Force Review Board
<b>IACP</b>	International Association of Chiefs of Police		
<b>ITAP</b>	Informal Training Accountability Protocol		

## About the COPS Office



**The Office of Community Oriented Policing Services (COPS Office)** is the component of the U.S. Department of Justice responsible for advancing the practice of community policing by the nation's state, local, territory, and tribal law enforcement agencies through information and grant resources. Since 1994, the COPS Office has invested nearly \$14 billion to add community policing officers to the nation's streets, enhance crime fighting technology, support crime prevention initiatives, and provide training and technical assistance to help advance community policing.

Rather than simply responding to crimes once they have been committed, community policing concentrates on preventing crime and eliminating the atmosphere of fear it creates. Earning the trust of the community and making those individuals stakeholders in their own safety enables law enforcement to better understand and address both the needs of the community and the factors that contribute to crime.

COPS Office resources, covering a wide breath of community policing topics—from school and campus safety to gang violence—are available, at no cost, through its online Resource Center at [www.cops.usdoj.gov](http://www.cops.usdoj.gov). This easy-to-navigate website is also the grant application portal, providing access to online application forms.

## About CNA



**CNA** is a not-for-profit organization based out of Alexandria, Virginia. The organization pioneered the field of operations research and analysis 70 years ago and, today, applies its efforts to a broad range of national security, defense, and public interest issues, including education, homeland security, public health, and criminal justice. CNA applies a multidisciplinary, field-

based approach to helping decision-makers develop sound policies, make better-informed decisions, and lead more effectively. CNA is the technical assistance provider for the U.S. Department of Justice, COPS Office Critical Response Technical Assistance Program.







**COPS**

*Community Oriented Policing Services*  
**U.S. Department of Justice**

U.S. Department of Justice  
Office of Community Oriented Policing Services  
145 N Street NE  
Washington, DC 20530

To obtain details on COPS Office programs,  
call the COPS Office Response Center at 800-421-6770.

Visit COPS Online at [www.cops.usdoj.gov](http://www.cops.usdoj.gov).

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