



City of Portland
Portland Police Bureau
Officer-Involved Shootings
and Critical Incidents

Ninth Report
January 2026



OIR

GROUP



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Introduction

This is our ninth report on Portland Police Bureau (“PPB” or “Bureau”) uses of deadly force and in-custody deaths. As in each of our prior eight reports, we provide a detailed description and in-depth analysis of each incident we review. Here, that includes nine officer-involved shootings and one death by suicide that occurred during the course of an interaction with PPB officers. In all, these 10 cases raise to 75 the total number of critical incidents involving the Police Bureau that we have reviewed over the past 15 years.

The themes we discuss in this report mirror many of those we have discussed in earlier reports. In fact, all of the incidents reviewed here occurred prior to our last report, which itself was produced nearly three years ago. Some of the delay is attributable to the normal pace of work and the protracted timetables for finalizing the various investigations and accountability processes that are prompted by these events. But the mechanics of City contracts and the newly created prohibition on reviewing cases before any associated litigation is completed (discussed more fully later in this report) play a bigger role.

The result is that the incidents discussed in this report are rooted in what seems like a different era, when concerns about the federal government’s role in the City were limited to issues surrounding enforcement of the settlement agreement with the U.S. Department of Justice (USDOJ). Portland is again in the national spotlight, less as a flashpoint in the movement for racial justice that sparked violence between ideological opposites and instead because of a standoff between the City and the federal executive branch – as manifested in the armed immigration enforcement agents whose presence the community and PPB must navigate.

Significant changes to Portland’s system of government and mechanisms for holding PPB officers accountable have also taken shape since the incidents we review here occurred. Likewise, the efforts to comply with the terms of the 2014 settlement agreement with the USDOJ have shifted

focus with the appointment of a federal monitor in 2024. The monitor is now responsible for assessing compliance with the terms of that agreement, which required the Bureau to make changes to the way it addressed mental health concerns and use of force issues, along with significant adjustments to the Bureau's investigative protocols and internal review processes. The monitor's regular reports provide the public a window into the PPB's ongoing efforts to achieve full compliance.

Against this larger backdrop, this report examines 10 incidents that occurred between 2019 and 2022. As with all our prior reports, we provide a detailed summary of the incident, followed by an assessment of the Bureau's investigative and review processes with particular attention to tactical decision-making, de-escalation efforts, and the effectiveness of supervisors to manage and direct resources and control the scene. And if the aforementioned time lag is an impediment to maximum efficiency, the intention behind this scrutiny remains to provide a constructive source of systemic improvement as well as transparency.

Of these 10 cases, two were fatal officer-involved shootings. There was one other fatality – an incident where the subject, Mr. Tran, took his own life during the course of a standoff with officers. Of the other seven officer-involved shootings, four were “non-hit” – in which officers fired at but did not strike the subjects. The remaining three were non-fatal “hit” shooting incidents where the subjects were struck by bullets but survived.

Three of the incidents involved officers shooting at a moving vehicle, a scenario that, in general, is problematic for law enforcement for a number of reasons. Two of the three cases we discuss here (involving Mr. Dahlen and Mr. Carr) highlighted some of these concerns, both relating to the futility and risks of shooting at a vehicle. The third (involving Mr. Keck) provided an example of the rare scenario where the downsides of shooting at a moving vehicle are outweighed by the importance of stopping the subject driving the car.

At least three of these incidents involved subjects (Mr. Henriksen, Stockton, and Merritt) who had some history of mental health issues or were experiencing some type of mental health crisis. The outcome of the incident involving Mr. Tran suggests he might also belong in this category. This commonality is a consistent theme across all the critical incidents we review – in Portland as well as other jurisdictions.

We have frequently commented on the Bureau's approach to behavioral health issues and its significant evolution since our first project with the City in 2010 – reviewing the Bureau's response to the 2006 death of James Chasse. The impact of the Bureau's emphasis on training officers to effectively communicate and exercise patience, along with its innovative use of resources to partner with behavioral health experts and clinicians to provide more effective responses to those in crisis, is evident in some of the incidents we reviewed.

For example, in Mr. Henriksen's case, a similar encounter with police three weeks prior to the shooting ended with the same officer (who was later involved in the shooting) taking him to the hospital on a mental health hold. That officer engaged with Mr. Henriksen on the day of the shooting, believing and hoping he could achieve the same outcome. And in the incident involving Mr. Tran, Crisis Negotiation Team members worked assiduously to engage with him in efforts to reach a peaceful resolution, over the course of roughly four hours. While the tragic outcomes in both of these cases may overshadow these efforts, we recognize the importance of acknowledging the Bureau's progress.

In two of these incidents (involving Mr. Henriksen and Mr. Merritt), the subjects explicitly expressed a desire to commit what is commonly characterized as "suicide by cop." We have been critical in past reports of the use of this terminology because it suggests inevitability: that there was nothing officers could do to prevent the use of deadly force. Instead, even in these scenarios where a subject seems determined to provoke police into firing with the intent of ending his own life, officers often retain the ability to impact the outcome of the incident. We were pleased to see in these two cases that the Bureau's review did not take the same "inevitability" perspective we have previously criticized and instead was rigorous in its analysis of the tactical decision making involved.

As with prior reports, our primary evaluation of these incidents is not intended to second-guess the outcomes, though we do point out areas of disagreement or where we see officer performance that appears to be inconsistent with Bureau directives and expectations. Instead, we focus on the Bureau's own internal investigations and review processes to evaluate how well they identify and respond to concerns with officer decision-making and, more broadly, systemic issues that may impact future incidents.

One significant critique of these cases is the lack of any consistent mechanism for considering the numerous recommendations made by the various entities who are part of the Bureau's multi-layer review process.

This has been a frequent theme of prior reports, and we have made recommendations addressing this deficiency at least four times in the past. We note it again here, with the observation that in a few cases memos from the Chief's Office were clear and direct in both their acceptance of recommendations and plan for implementation. In this report, we advocate for a systematic approach that would make this practice consistent, with a formal process for centralized consideration and documentation of all recommendations stemming from a critical incident.

Another significant systemic change that we have repeatedly advocated for is that the Bureau make formal findings on decision-making by involved personnel *prior* to the use of deadly force. The cases reviewed in this report do not reflect any movement by the Bureau on this issue. Use of force experts have increasingly recognized that use of deadly force is integrally tied to the tactical and officer safety-related decisions that precede it. Recently, the United States Supreme Court considered a question in which "officer created jeopardy" may have been central to why the shooting occurred, with a fact pattern similar to the incident involving Mr. Dahlen that we discuss in this report. While the Bureau has for years made detailed formal findings on how its officers and supervisors respond to a deadly force event *after* shots are fired, it still declines to make formal findings on decisions made prior to the deadly force incident, despite our repeated recommendations to do so. We urge the Bureau to again consider this crucial recommendation.

We note one change in our regular reporting practice. In the past, we have provided a timeline of the investigation and review process in each case. The Bureau's agreement with the USDOJ requires it to complete the investigative and review process of officer-involved shootings within 180 days. Because the incidents we review here happened three to six years ago, observations about timing would not necessarily be reflective of the Bureau's current practices. Because compliance with this settlement agreement requirement is now being supervised by a federal monitor, we have not engaged in this analysis for the current set of cases.

Our process for reviewing incidents has not changed over the course of our 15-year engagement with the City. As we have done for each of our prior reports, we reviewed all of the Bureau's investigative materials for each of the 10 critical incidents we evaluate here, including the Detectives' and Internal Affairs' investigations, as well as grand jury transcripts where available. We also read and considered the Training Division Review and materials documenting the Bureau's internal review and decision-making process connected with each incident. We talked with Bureau executives regarding questions that were not answered in the initial materials provided and requested additional documents that were responsive to those questions.

One aspect of our review process that is standard in our work with jurisdictions other than Portland is the review of body-worn camera footage. We applaud the Bureau's relatively recent adoption of body-worn camera technology. While these videos certainly have limitations (generally related to perspective, lighting, and angles), they often provide a more complete picture of the incident and have become an integral part of any rigorous review of officers' uses of force.

Finally, we acknowledge the Bureau's cooperation and willingness to engage with us on the issues raised in this report. This has been another consistent aspect of our work in Portland. We appreciate leadership's receptivity to our suggestions, generosity with their time, and candor with their responses to our questions and concerns.

Officer-Involved Shootings and Uses of Deadly Force

January 2, 2019 ◦ Anita Ruiz

Shortly before midnight on January 2, 2019, a woman called 911 to report that her aunt had pushed her to the ground during a domestic dispute. The woman said she and her boyfriend were outside an apartment building waiting for officers to respond. Officer Brian Galego was dispatched to the call and Officer Onest Robert responded to provide cover. The officers coordinated their arrival at the location and were beginning to gather information from the caller when they heard a woman yelling for help from inside one apartment. The caller told them it was her aunt and that officers should go check on her.

The officers approached and knocked on the apartment door, where they could hear the woman continuing to call for help. They announced, "Police!" and then opened the unlocked door. From the entrance, they saw a woman lying on the floor with a man sitting on top of her. The officers gave orders for the man to get off the woman. He complied and moved outside of the apartment, behind the officers.

The woman, later identified as Anita Ruiz, then quickly got up from the floor, walked into the kitchen, and returned with a kitchen knife raised to shoulder height, saying repeatedly, "I'm going to kill him. I'm going to fucking kill him." Both officers drew their handguns as they began backing out of the apartment and giving Ms. Ruiz commands to drop the knife. She continued to advance quickly toward the officers, and Officer Robert fired one round as both officers backed out of the apartment and allowed the door to automatically close.

Officers briefly re-grouped, then slowly opened the door while calling for the woman to come out with her hands in the air. Ms. Ruiz complied, then got on the floor and submitted to handcuffing. She was not hit and suffered no injuries.

A lieutenant, three sergeants, and other officers arrived and took control of the subject and the scene. They cleared the apartment to ensure there were no other occupants and no one had been hurt. Officer Robert's single bullet was found embedded in the wall. Officers also recovered a large kitchen knife that Officers Robert and Galego identified as the knife Ms. Ruiz had held.

Ms. Ruiz was arrested and ultimately pled guilty to misdemeanor unlawful use of a weapon.

The District Attorney presented the case to the Grand Jury, which determined that Officer Robert's use of force was justified.

The Bureau and Police Review Board (PRB) concluded the officer and supervisors all acted in accordance with policy. The Commander reviewing the case did determine, however, that Officer Robert should have waited for an additional cover officer before taking Ms. Ruiz into custody. The tactical preference, detailed in the Training Division Review, would have been to hold her at gunpoint while awaiting backup to ensure the smoothest and safest transition to custody. The case disposition included a debriefing regarding these tactical options.

OIR Group Analysis

This incident was relatively brief and straightforward. Officers responded appropriately to a domestic disturbance, with the primary officer waiting just off-scene for his cover officer before approaching the location. As they began gathering information from the 911 caller, their response took on new urgency when they heard the female subject calling for help. They announced themselves, then opened the unlocked door as the cries for help continued. Within seconds, Ms. Ruiz was advancing toward the officers with a large knife raised to shoulder height, as if ready to strike.

Both officers began backing out of the doorway. Officer Galego believed he could make it out and shut the door before she reached them. Officer

Robert calculated the time and distance differently and believed he could not safely make it out of the apartment before she reached him and his partner. He fired one round to address this threat. The Training Division Review did not directly address the difference in the two officers' perceptions, but did determine that Officer Robert's actions "demonstrate[d] sound and effective tactics." We see this dynamic frequently, where two officers in the same stressful encounter independently reach different decisions about the best tactical response. Because each officer is positioned differently and brings his or her own skills and perspectives to the situation, it is reasonable and understandable when they make different decisions about the appropriate use of force. It would have been helpful to see this dynamic addressed more explicitly in the Training Division Review.

Training did call out Officer Robert's decision to take Ms. Ruiz into custody without waiting for backup officers to arrive while also praising the decision to quickly reengage with her to see if she needed medical care. After the shot was fired and officers were outside the apartment, they called out to Ms. Ruiz, then opened the front door. Officer Robert stood at the threshold with Officer Galego providing lethal cover. They could see the knife on the ground but could not see Ms. Ruiz. Officer Robert again called out to Ms. Ruiz, who responded and said she was not injured. She complied with commands to come out, get on the floor, and submit to handcuffing.

We appreciate and agree with Training's analysis. One option would have been for officers to wait for additional resources before even reentering the apartment. But if Ms. Ruiz had been struck by Officer Robert's bullet, the decision to wait could have proven fatal. Quickly engaging was consistent with respect and concern for Ms. Ruiz's life. Training found, though, that once they confirmed Ms. Ruiz was not injured, the better option would have been to wait for backup prior to going hands-on with her, to minimize the possibility of her resistance and any additional use of force. As noted above, the Bureau conducted a debriefing on this tactical decision.

Consistent with its usual practice, the Bureau's review thoroughly covered issues with the post-shooting supervisory response, which it found to comply with all policies and training standards. We noted in particular the Bureau's focus on the fact that a sergeant participated in the clearing of the apartment after Ms. Ruiz had been taken into custody. Sergeants'

tendency to step into the role of officers rather than maintain their supervisory presence has been a frequent issue of discussion in our prior reports. Here, the reports and interviews acknowledge this concern and document valid reasons for the sergeant's actions: there was another sergeant on scene acting as a supervisor, and the exigency in clearing the apartment to ensure there was no one else present who may have been struck by Officer Robert's bullet made waiting for an additional officer to assist the clearing team impractical and unwise. We appreciate both the Bureau's effort to focus on this issue and the sergeant's justification for taking on the duty of clearing the apartment.

December 8, 2019 ◦ Koben Henriksen

At around 1:45 in the afternoon on Sunday, December 8, 2019, eight separate callers dialed 911 to report a man moving in and out of traffic at a busy intersection and pointing or waving a knife at cars passing through. The callers were relatively consistent in their physical descriptions of the man, including a distinctive blanket draped over his shoulders, though some said he had a knife in each hand, while others reported seeing one knife. Callers also reported that the man had threatened at least one driver who was waiting in a Starbucks drive-through line.

Among the officers who responded to the call were Officers Daniel Leonard and Justin Raphael. Officer Shawn Schroeder was the primary officer, initially assigned to the call. When he heard the broadcast, Officer Raphael associated it with a call he'd handled a few weeks earlier, which was similar in description of the circumstances and subject, and in which he said the subject had attempted to induce officers to shoot him in a "suicide by cop"¹ incident.² He broadcast this information so that other responding officers would be aware of the possibility it was the same individual.

The three officers initially staged a few blocks from the call and quickly divided responsibilities, with Officer Raphael designated as lethal cover, while Officer Leonard would be ready with his less lethal launcher and Officer Schroeder would take the role of communication and hands-on officer.³ They then approached the intersection, making the decision to move in without lights and sirens in an attempt to avoid escalating the situation. When they arrived at the location, they quickly located the man, later identified as Koben Henriksen, who matched the physical

¹ We have been critical in the past of law enforcement's use of the verbiage "suicide by cop" and discuss this issue above.

² That case did, in fact, involve Mr. Henriksen. Officers, including Officer Raphael, were able to de-escalate the situation and convince Mr. Henriksen to drop the knife he was holding. He was taken to the hospital on a mental health hold.

³ As the scenario unfolded, Officer Raphael became the primary communicator with Mr. Henriksen. This made sense, given his success at de-escalating their prior encounter.

descriptions provided by the various callers and was holding a knife in each hand.

Officer Schroeder arrived on scene first and began giving Mr. Henriksen commands to drop the knives. He initially stood at his own patrol car but then moved to the passenger side of Officer Raphael's car, which was parked next to his.

Officer Leonard arrived seconds after the others and parked his patrol vehicle in the middle of the intersection, positioning the car with the intention of blocking the intersection and preventing other vehicles or pedestrians from entering. As he parked and loaded his 40mm launcher, he heard the other officers addressing Mr. Henriksen as the subject moved toward them.

Officer Raphael armed himself with his rifle, having made the decision this was the best weapon given the circumstances because of its accuracy and unlikelihood of rounds over penetrating and causing harm to the numerous people present in the area.

Officer Raphael hoped Mr. Henriksen would recognize him and recall the peaceful outcome from three weeks prior, so called out to him something to the effect of "don't you remember me? I'm the officer from a few weeks ago." And, "please let us help you again." Mr. Henriksen responded, "I don't fucking care. I'm going to fucking kill you." He then began walking quickly toward Officer Raphael, who warned him he would be shot if he didn't stop and drop the knives. Mr. Henriksen responded, "do it!"

When Mr. Henriksen was approximately 12 to 15 feet from him, Officer Raphael fired his rifle three times, striking Mr. Henriksen in his head, chest, and abdomen, causing him to fall to the ground. Officer Leonard simultaneously fired one less lethal round, striking Mr. Henriksen in his back, near his shoulder. The shooting occurred less than a minute after officers arrived on scene and seven minutes after the initial 911 calls.

A fourth officer, Officer Richard Bailey, arrived just as shots were fired. Along with Officers Schroeder and Leonard, he approached Mr. Henriksen, moved the two knives out of harm's way, and began to assess his wounds and provide aid. EMT personnel arrived within moments and took over medical care. Mr. Henriksen was pronounced deceased at the

scene. The medical examiner determined that each of the three gunshot wounds would have been fatal, independent of the others.

Two folding knives were recovered at the scene, with blades measuring three and nearly four inches long.

The shooting incident was partially captured on a video taken by a Tri-met bus as it approached the intersection. In that video, Mr. Henriksen is seen walking briskly toward officers as Officer Raphael fired his weapon.

Homicide detectives interviewed over 20 independent witnesses. While many differed on small details, almost all were consistent on the major events – Mr. Henriksen’s possession of knives, his rapid movement toward officers, and officers’ commands and warnings.

Three witnesses provided accounts that were substantially different. Two of these said Mr. Henriksen was not moving toward officers when he was shot; both witnessed the incident from their vehicles while waiting in the Starbucks line. A third witness said Mr. Henriksen had his hands down and was not holding a weapon as he walked toward police in a non-threatening way. All three witness statements contradicted a large number of other witnesses, as well as the video evidence.⁴ The IA investigator identified and discussed these discrepancies while noting in the investigative report the ways in which individual perception can be impacted by location, perceptual distortions, biases, and prior experiences.

The District Attorney presented the case to the Grand Jury, which returned a not true bill regarding the officers’ uses of force.

The Bureau and the Police Review Board both concluded that officers’ and supervisors’ actions were in policy. A minority of the Police Review Board recommended that Officer Leonard should receive a debriefing for not providing a warning prior to his use of less-lethal force. The Police Commissioner concurred and the debriefing was conducted.

⁴ These three witnesses testified in the Grand Jury proceedings, along with 15 other civilian witnesses.

OIR Group Analysis

Though the shooting was found to be within policy, the Bureau engaged in a rigorous discussion and review of the tactical decision making and supervisory issues involved, in both the IA investigation and in the Training Division review. We discuss the Bureau's analysis, along with issues identified in our review below.

Planning and Approach

Once officers arrived on scene and identified themselves to Mr. Henriksen, events unfolded very quickly, with Mr. Henriksen advancing on Officer Raphael. Prior to that, officers briefly met several blocks away to discuss their approach. The three officers discussed their designated roles and a plan to arrive together, but hastened their planning and any further coordination as 911 calls continued and the threat to the public appeared to be escalating.

Ideally, officers would have had time for a more coordinated approach. But the numerous calls about an armed subject walking into traffic in a busy intersection and approaching individuals in their cars heightened officers' sense of obligation to intervene quickly. The exigency created a response that was, according to the Training Division Review, within the range of accepted tactical options, but that nonetheless raised some areas of discussion for potential improvement.

Notably, Officer Leonard was unable to load his 40mm launcher prior to arriving at the scene to prepare for quick deployment. By the time he could retrieve, load, and deploy the weapon, Mr. Henriksen had already begun his advance on Officer Raphael, limiting any likelihood that the less-lethal option would make a meaningful impact on the outcome. The Training Division Review focused on this issue and included a formal recommendation that future training include an emphasis on the importance of preparing the 40mm prior to arrival at the scene whenever possible.

Officer Leonard also arrived at the scene just after the other two officers and, instead of positioning himself next to the others, decided to take a position in the middle of the roadway, somewhat apart from the others.

This left the officer designated as lethal cover (Officer Raphael) at a distance from the less-lethal cover, with each of them unsure of how the other was responding. Ideally, the two would have arrived at the same location at the same time and been standing side-by-side when they confronted Mr. Henriksen.

This positioning issue was not identified in the Training Division review but was discussed by a different representative of Training during his Grand Jury testimony. While the optimal response may have had the officers standing next to each other, the training officer concluded this wouldn't have changed the outcome here. As Mr. Henriksen advanced rapidly toward him, Officer Raphael perceived the threat and responded with deadly force. Officer Leonard fired his less-lethal weapon nearly simultaneously. The exigency of the threat did not give Officer Raphael time to wait and see if the less-lethal projectile would stop or slow Mr. Henriksen's advance, regardless of the position from which Officer Leonard fired it.

While the circumstances limited officers' ability to coordinate and communicate prior to arriving on scene, the Training review noted that officers nonetheless did some things well in the course of their hastened response. Officers positioned their vehicles approximately 40 yards from Mr. Henriksen, giving themselves some distance and cover as they attempted to communicate with him. Officer Raphael was hopeful he could de-escalate the situation as he had in the prior weeks and began by reminding Mr. Henriksen of that encounter. Instead of engaging with officers, though, Mr. Henriksen advanced quickly, imploring them to shoot.

Witness Interviews

Detectives ushered a large number of witnesses to this incident onto buses while they waited to be interviewed. They were instructed not to speak with each other. Training noted: "asking community members to sit on a bus for several hours after witnessing a traumatic event and told [sic] not to speak to each other shows a lack of compassion." The review recommended that people should be allowed to leave after providing an

officer with a statement and contact information. Detectives can follow up with witnesses at a later time.⁵

The Bureau's investigation and review also noted and addressed an issue involving Officer Schroeder's interactions with witnesses after the incident. As a witness himself, he should have been immediately sequestered. Instead, he began assisting with the identification and interview of civilian witnesses. Because the scene was chaotic, responding sergeants did not immediately realize that Schroeder had been involved. An experienced officer would know that he should inform the sergeant of his role, but Officer Schroeder was still a trainee at the time, and the Training review concluded it was reasonable that he did not know to do this.

Questions about Alternatives (Taser Use)

As with so many other PPB officer-involved shootings we've reviewed, this case raises questions about the options officers have when responding to subjects with knives or other edged weapons. In particular here, some witnesses and Grand Jury members questioned why officers did not use some alternative to deadly force to stop Mr. Henriksen's advance and specifically wanted to know why officers had not used Tasers in this situation.

In response to those questions, the Training Division Review noted that a Taser, or Conductive Energy Weapon (CEW), is not the preferred tool in a situation like this. By the time a subject with a knife is within the CEW's maximum range of 25 feet, the subject is so close to the officers that a failed Taser deployment leaves officers vulnerable to a knife attack. Further, Mr. Henriksen was draped in a heavy blanket that partially covered his torso, which could have limited the ability of Taser probes to make successful impact.

⁵ In addition to the issue identified by Training, while we understand that witnesses were advised that they were free to leave but then asked to remain, we have reviewed instances (including a Bureau officer-involved shooting) in which there were later allegations that the witnesses were being "detained" and not free to leave, sometimes resulting in liability for the jurisdiction. When witnesses are asked to remain, the agency should obtain a recorded statement and/or signed waiver indicating that the witnesses are remaining on scene of their own accord.

We have noted in past reports the understandable frustration of the public that officers have not developed better ways to stop subjects with edged weapons. Training personnel in this and other agencies have been grappling with this issue for as long as subjects have had knives. Officers here used the best defense against knives available: Distance. But Mr. Henriksen closed the 40-yard gap quickly, limiting officers' options. The Bureau – along with law enforcement professionals generally – continues to research and explore innovative tools and new ways of thinking about these issues that might result in different outcomes.⁶

Mental Health Concerns

Mr. Henriksen's history of struggles with his mental health became public in the days following this shooting. The evidence presented to the Grand Jury included information about a report from a mental health caseworker dated a few days after the November 14 incident. Then, Mr. Henriksen told his caseworker he was trying to get police to shoot him and was surprised that officers had not. The night before this incident, Mr. Henriksen left a voicemail for his caseworker in which he talks about his despair at never being able to get housing, feeling trapped, and his intention to go on a "suicide mission."

We note this only as an observation of the challenges facing the City, the Bureau, and the mental health community in addressing the persistent and pernicious societal issues that continue to create scenarios such as this one.

⁶ For example, the newest Taser model attempts to address some of these issues, with a longer range, probes that are intended to be better at penetrating through clothing, and the ability to more precisely aim and fire probes at a subject.

June 28, 2020 ◦ Gray Stockton

Around 2:30 in the afternoon on June 28th, 2020, a realtor called 911 to report the apparent presence of a squatter in a vacant townhouse he had listed for sale. Officers Laurent Bonczijk, Zachary Kenney, and Derrick Daley (a trainee who was working with his training officer, Officer Kenney) responded and spoke with the realtor, who communicated the owner's wish to have the officers clear the property. As they walked the outside perimeter of the townhouse, they noted shattered glass on a back door, and observed through a window clothing and papers scattered in the home.

Officers considered calling and waiting for additional resources. Staffing shortages and the relatively minor nature of the suspected crime weighed against that decision. Officers made a plan to enter and clear the four-story building.

They cleared each of the first three floors, calling out, "Portland Police Bureau" and providing warnings about the potential use of force throughout. They heard no signs of any movement as they made their way through the townhouse. When they reached the stairs to the top floor, they observed some handwritten notes on the floor. Among those were notes that stated:

This is my house. I am deaf and mute. Purchase papers on file @ Barclays, the English Bank. Explain why you are trespassing in writing.

And:

I am armed & infected with a deadly virus.

The officers interpreted these notes to be an attempt to keep other squatters away from the property or provide legal justification for their presence, and did not consider them to contain necessarily true statements. They also observed that the notes (which included a number of random and presumably delusional statements, such as the reference to being a "CIA prisoner") coupled with the scattered belongings

throughout the house, possibly indicated the existence of a mental health issue.

The door to the top floor master bedroom was closed. The officers again announced their presence, then made entry to the room and began clearing it. Within the room was a narrow hallway that led to a bathroom and walk-in closet. They continued to announce their presence as they moved through the suite. As Officer Bonczijk looked into the closet, he saw the subject (later identified as Gray Stockton) pointing a gun at him. Officer Bonczijk raised his weapon and fired three shots before retreating out of the bedroom with the other officers.

Officer Kenney broadcast that shots had been fired and requested medical assistance and additional resources, including K-9 and a shield. From the landing outside the bedroom, Officer Kenney gave commands for the subject to toss the gun out, to come out from the closet, or to give some indication that he needed assistance so they could render aid. Mr. Stockton was not responsive.

Sergeant Darke Hull was the first supervisor to respond. He activated SERT while enroute and assumed command when he arrived on scene. He directed the involved officers out of the residence and assembled other resources – including AR-15 and less-lethal 40 mm operators – on the staircase outside the bedroom. Officers continued communicating with the subject, who remained unresponsive.

The SERT team arrived within about an hour and took over the tactical situation after a briefing from Sgt. Hull. SERT deployed a robot to reach Mr. Stockton, who ultimately surrendered without further incident. Officers took him into custody nearly two hours after shots had been fired. Mr. Stockton was uninjured. SERT members located a pellet gun that closely resembled a handgun on a shelf in the closet.

Because Mr. Stockton was not injured in the incident, the District Attorney was not required to present this officer-involved shooting to a Grand Jury for consideration of possible criminal charges and used his discretion to determine that Grand Jury review of this case was not warranted.

The Bureau and the Police Review Board both concluded the shooting officer and the supervisors responding to the incident acted within policy. The PRB also recommended that the Bureau pursue and adopt the

detailed recommendations made by the Training Division (discussed below).

OIR Group Analysis

Though the shooting was found to be within policy, there were nonetheless a number of issues surrounding tactical decision making that were an important part of the Bureau's review of this incident. The Bureau's investigations thoroughly addressed all questions around these tactical and supervisory issues. The Training Division review provided a detailed and comprehensive discussion and evaluation of each significant action and decision and identified areas for potential improvement. The issues identified in our review, along with a discussion of the Bureau's analysis of each, follows below.

Decisions around Entry and Search of the Property

Responding officers initially viewed this as a routine call involving a squatter or squatters in a vacant home. Their decision making was based on this assessment, coupled with significant staffing concerns that resulted in efficiency taking priority over the ideal.

The Training review notes that officers ideally would have waited for an additional unit and requested a K9 unit begin responding before entering the house. At the same time, Training acknowledges that the Bureau was consistently running below minimum staffing at the time due to the strain of the ongoing civil unrest. There was just a single K9 unit available in the entire city that day. Further, the low level of the suspected crime (criminal trespassing) would have made deployment of a K9 in this scenario questionable. When interviewed, the officers and responding sergeants clearly expressed that it would have been unrealistic to expect additional units and resources at the outset of this seemingly routine call. The Bureau thoroughly evaluated this view and concluded the officers' decision to enter the house were consistent with Bureau expectations.

As the officers moved through the lower floors of the home to clear the location, they did not re-assess their initial view that this was a "typical" squatter call, despite acknowledging that the home did not look like it was occupied by the typical squatters – largely because of the presence of the

notes throughout the house. Because some of those notes were clearly false (ownership of the property, for example) or delusional (being a CIA prisoner, for example), the officers dismissed them all as either self-serving or the product of mental illness. They did not consider that the statement about being deaf and mute might be true.⁷

The Training review noted that the officers ideally would have paused to consider that the subject could be unable to hear their announcements and to assess and discuss ways that might alter their tactical approach. It might have been possible at that point to have waited for a K9 and avoided the shooting incident by using the dog to clear the bedroom and closet.

Nonetheless – while Training appropriately identifies the failure to reassess based on the discovery of new evidence as an area for improvement – it is not clear that the officers' tactics would or could have changed, even with more deliberate consideration of the import of the notes. SERT leaders indicated they likely would not have responded to take over clearing the location based only on the information in the notes, and the timing and availability of a K9 was uncertain, so the officers likely would have been in the same situation of needing to physically clear the location.

Decision to Shoot

When interviewed, Officer Bonczijk stated that when he opened the closet door, he first saw the subject's feet and as his eyes tracked upward, he saw a gun pointed directly at his face. He instinctively moved away, and said the gun tracked his movement and he saw the subject in what he described as the perfect shooting position, aiming his gun at the officer. Officer Bonczijk quickly fired three rounds as he shouted "gun" to his

⁷ The detectives who later interviewed Mr. Stockton believed he could hear based on the way he reacted to their questions, but he would only respond in writing. Officer Bonczijk's account – that Mr. Stockton had the gun ready and pointed at him when he opened the closet door – is supportive evidence of Mr. Stockton's ability to hear and his awareness of the officer's presence in the bedroom.

partners.⁸ His backdrop for the shooting was the rear of the closet and the exterior wall of the townhouse.

The Bureau's decision makers and the PRB assessed various factors around Officer Bonczijk's decision to fire his weapon. All concluded the shooting was within policy. The Training Division found the decision to shoot to be an acceptable tactical option.

Decision to Wait for SERT to Take Subject into Custody

After shots were fired, officers quickly retreated from the room to reassess. Officers' priority was to get a medical response to Mr. Stockton as quickly as possible while protecting the safety of officers and preventing any additional shooting or use of force. Officer Kenney requested an ambulance, a tactical shield, and other resources, while Sgt. Hull activated SERT and likewise requested key resources.

Ultimately, the decision was made to wait for SERT to respond rather than having officers attempt to contact Mr. Stockton. Officers knew Mr. Stockton was armed, but did not know whether he had been hit by gunfire. His inability or unwillingness to communicate with officers created additional uncertainty. SERT was able to deploy a robot to assess Mr. Stockton's condition and ultimately took him into custody without incident, roughly two hours after shots were fired.

Here, the subject was uninjured, providing easy confirmation of the wisdom of the slow, deliberate approach to taking him into custody. Had he been struck and wounded by the officer's gunfire, however, the two hours it took to reach and assess him could have been tragic. The Training Division review acknowledged this but concluded that waiting for the relative safety of a SERT response was a reasonable and appropriate decision. Training also noted that officers could have used a drone to approach and assess Mr. Stockton, had that resource been available to the Bureau at the time.

⁸ Of the two witness officers, one reported hearing Officer Bonczijk say "gun" while the other recalls him saying "oh shit." These differences are understandable, given the impact of stress dynamics on perception and memory.

Supervisory Issues

The overall post-shooting supervision was efficient, effective, and in compliance with Bureau policy and expectations. There were a number of questions and issues raised, however, largely related to staffing concerns and challenges. These were all thoroughly examined in the Training Division review.

For example, when Sgt. Hull arrived on scene, he immediately removed Officer Bonczijk from the scene and ensured his segregation from others. He recognized that Officer Kenney should likewise be removed, but also realized that Kenney was the only officer on scene at the time with the experience and seniority to manage the containment of the subject while waiting for SERT and additional resources. Sgt. Hull made the conscious and well-considered decision to leave him in place, despite his status as a witness to the shooting.

There were other issues of confusion around supervisory response, again largely related to thinly stretched staffing. This incident coincided with the response to an earlier critical incident, and the second sergeant to arrive on scene had to leave that scene to respond to this shooting. This third supervisor to arrive, a Lieutenant, was off duty at the time and responded directly from his home. In addition to creating staffing shortfalls, the high number of retirements and resignations during this period created confusion about who was acting in what role. During this incident, there were two Sergeants serving as acting Lieutenants, a Lieutenant acting as Captain, and an acting Commander serving as acting Assistant Chief. In the end, Training concluded that supervisors performed well, but the appearance of confusion was less than ideal.

Another notable issue – an offshoot of this confusion – was the lack of timely notification of Professional Standards Division (PSD). Sgt. Scott had the responsibility of making notifications, and noted that a PSD lieutenant was on scene. However, that lieutenant was there as an acting Captain with a different responsibility and was not representing PSD. This was eventually remedied, and PSD effectively conducted its investigation. This issue regarding PSD notification was also raised in the incident involving Mr. Henriksen, with a recommended solution that post-dated this incident. Our understanding is that the notification protocols have been amended to address these concerns since the time of this incident.

Training Division Review

The Training Division review in this case was exceptionally well done. It was thorough and detailed (as is typical of the work from Training on these reviews) in its examination of officer and supervisor decision making and performance. But it went a step beyond that, moving past what was a seemingly straightforward analysis – a non-hit shooting involving an uninjured subject who pointed a gun at an officer – to view the incident as a “near miss” worthy of extensive analysis related to a series of systemic issues. Had Mr. Stockton been killed in this officer-involved shooting, outside scrutiny from the public would have been substantially greater, and Training’s willingness to dive deeply into preventable aspects of this incident is commendable.

The analysis centered on three issues:

- **Technology.** Several participants in this incident noted how useful a drone would have been, both to search the townhouse and to assess the subject after the shooting. Training weighed in on this with a formal recommendation and the Bureau now has a functioning drone (also referred to as “Unmanned Aerial System”) program.
- **Staffing.** The Bureau’s chronic understaffing at the time of this incident created an informal emphasis on “efficiency over effectiveness” that showed up not just in this incident involving Mr. Stockton, but as noted by Training, in prior officer-involved shootings as well as everyday patrol operations. Training noted that it had become common for officers to minimize responses and move ahead without backup because of personnel shortages, in conflict with training doctrine, which advocates waiting for additional resources to address many scenarios. This lack of alignment between training and practicality led Training to recommend establishment of a workgroup to reassess the call response doctrine to reflect operational realities.
- **Supervision.** The analysis of this incident concluded that the supervisory response was within Training Division expectations. Yet it also noted some aspects of the response that were not ideal,

mainly related back to resource and staffing issues. Some of these – like the decision not to remove Officer Kenney from the scene because his experience was needed – were discussed above. More broadly, though, Training noted that the confusion around who was serving in which function was another “near-miss.” Personnel on scene for this incident overcame the confusion and performed effectively, but Training recognized there is no guarantee that a future incident would have a similarly positive outcome.

The Training review noted the ongoing struggle to provide leadership training throughout the organization. The Bureau’s heavy reliance on officers serving as Acting Sergeants created a need for quick expansion of the Bureau’s leadership program, to allow all officers interested and eligible for promotion to attend the New Sergeant’s Academy and to create additional training opportunities to compensate for the lack of experience among the supervisor ranks.

The Training Division Review concludes with four detailed recommendations related to its in-depth analysis. In short, they are:

1. Establish a drone program.
2. Refine the practice for updating the contact list for officer-involved shooting notifications.
3. Re-examine training doctrine to ensure it matches staffing realities.
4. Focus on additional employee development and leadership training.

The Bureau has addressed each of these recommendations.

December 24, 2020 ◦ David Dahlen

Two PPB officers responded to a call of a stolen truck after the owners spotted it on the streets of Portland. The officers located the large truck, which had oversized and raised tires, parked at a gas station. Officer Jennifer Pierce placed her car at a 45-degree angle in front of the truck while Officer Peter Braun drove directly behind the truck, nudging the bumper. As the officers maneuvered their vehicles, the driver jumped back into the truck and turned on the ignition.

Officer Pierce exited her vehicle and the truck drove forward, pinning her between her car and the front bumper of the truck. Officer Pierce fired her handgun twice, with both rounds striking the windshield of the truck. The shots fired by Officer Pierce were not effective as the truck continued to push forward but Officer Pierce was then able to jump into the driver's seat of her patrol car. The truck pushed past Officer Pierce's car and fled the scene. The truck was later found unoccupied. PPB supervisors responded and ordered medical assistance for Officer Pierce, who was transported to the hospital.

Mr. Dahlen was eventually identified as the driver and arrested later that day. He indicated that he had not been struck by the bullets fired at him and told detectives that he believed the shots were coming from behind him. After he was placed in a holding cell, the cleaning personnel left the cell unsecured, allowing Mr. Dahlen to escape. He was eventually rearrested several days later.⁹

Officer Pierce suffered serious injuries as a result of the incident. The District Attorney decided not to present the use of deadly force to the

⁹ There was no further reference in the file regarding whether the circumstances surrounding Mr. Dahlen's escape were investigated by the Bureau, though it was stated that changes were made as a result of this custody failure. It would have been helpful for the Bureau, consistent with its commitment to transparency, to discuss the issues surrounding this custody failure and any reforms intended to prevent future escapes.

Grand Jury, based on the facts. Mr. Dahlen was indicted for attempted murder and eventually pleaded guilty to the charge.

Following an internal investigation, the Bureau found that Officer Pierce's use of force was in policy. The Bureau also found no policy violations relating to post-incident scene management by responding supervisors.

The Police Review Board met and likewise found neither the officer nor supervisors had violated any Bureau policies. With regard to the scene management issue, the Board did recommend that the Training Division produce a uniform checklist for incidents such as officer-involved shootings, so acting sergeants, as well as all employees, would have adequate resources with which to respond during chaotic situations. The Training Division advised that the recommendation for such a checklist was adopted and since then has continued to be updated.

OIR Group Analysis

Training Division Review

While neither the Bureau nor the Review Board found violations of policy, the Training Division Review identified significant issues regarding the actions and decision-making of the responding officers. Training noted that the decision by the officers to arrive on scene simultaneously was consistent with training, providing the officers with numerical superiority, but also found that the response could have benefitted by the officers developing an arrest plan and communicating around this plan. The lack of planning resulted in confusion regarding whether a box-in of the vehicle was being performed. The analysis further found that the officers could have mitigated the planning and communication issues by "staging" away from the scene so they could observe the location and plan their response before taking enforcement action.

Training also noted that Officer Pierce was mistaken in believing that Mr. Dahlen was not in a position to get back in the truck as she positioned her vehicle in front of him. As a result, her positioning placed her driver-side vehicle door directly in front of the truck, with enough room available for the truck to gain momentum by accelerating forward. Training's analysis also found that the positioning of the officer's vehicle would not have prevented the driver from fleeing on foot even though that was the officer's stated intention. Officer Pierce then realized her positioning of the patrol

car placed her in danger, but not in time to avoid being struck and pinned by the truck as Mr. Dahlen accelerated forward.

PPB training advises against positioning a patrol vehicle in front of a subject vehicle that is capable of being driven. Training noted that its Patrol Vehicle Operations Program has emphasized the need for both patrol vehicles to make contact when performing a “box-in” and that modifying the maneuver creates danger for the officer. The analysis stressed that it is imperative for the officer to align the patrol vehicle properly (not exposing the driver’s side to the front of the vehicle) and contact the suspect vehicle so that it cannot gain momentum. It contrasted Officer Pierce’s positioning with the correct positioning of Officer Braun’s vehicle behind the subject’s truck. It also noted that PPB training, consistent with PPB’s use of force policy, advises members against placing themselves in a position where a suspect can employ a vehicle against them as a weapon.

Training opined that Officer Pierce reasonably believed her life to be in danger and at one point was able to fire two shots at Mr. Dahlen. The analysis noted that the officer was aware that another person was in the truck and considered her backdrop by aiming upward, thereby reducing the danger to the truck’s passenger and the other responding officer. Training indicated that it generally discourages firing at moving vehicles but recognized this case as an exception to that advice because it opined that shooting at Mr. Dahlen might reasonably change his behavior, either by incapacitating him, causing him to flee, distracting him, or causing him to surrender. As a result, the Training review concluded that Officer Pierce’s decision to shoot at Mr. Dahlen was consistent with training.

With regard to the supervision of the scene after the shooting, Training first observed that having acting or inexperienced supervisors responding to officer-involved shootings has been a common theme over recent years. In this incident, two Acting responded to the incident followed by a sergeant from another precinct. The Training review noted that there was some confusion over who was the Incident Commander when the sergeant arrived and opined that it was not clear whether the two acting sergeants even recognized the need for a designated Incident Commander. The analysis concluded that this lack of experience or knowledge constituted a “near miss” since the sergeant arrived within minutes and assumed the role of Incident Commander.

Several weeks after this incident, the Training Division addressed the identified issue of officers improperly (and dangerously) positioning their vehicle in front of a suspect vehicle by delivering Bureau-wide training. Training further recommended that its Supervisor's In-Service training be made available to acting sergeants and those likely to assume an acting sergeant role. The analysis further renewed a recommendation made earlier to assign long-term acting sergeants a mentor sergeant. There is no indication in the file whether the Bureau adopted or implemented either of these recommendations.

Poor Planning and Communication

As detailed above, the Training Division review found that the two responding officers' performance could have been improved had they communicated better and considered developing a plan that would have more safely and effectively taken Mr. Dahlen into custody. However, Training made no recommendations designed to address the deficiencies identified. Moreover, neither PPB nor the Police Review Board considered the sub-optimal decision-making identified by Training in their reviews of the incident. As a result, the Training expert's critique of the involved officers' initial response did not result in any remediation for the involved officers or systemic learning opportunities for other Bureau members.

Officer-Created Jeopardy and the Importance of Addressing Tactical Decision Making

As detailed above, the Training review was also candidly critical of Officer Pierce's positioning of her vehicle and her decision to then quickly exit the patrol car, placing her in harm's way. That decision was a textbook example of the concept of "officer-created jeopardy" where the use of tactics that are unsafe or inconsistent with training places officers in a situation in which they may then feel a necessity to use deadly force. PPB's Training Division should be credited with its prompt response to this issue by providing Bureau-wide training to its officers that involved the particular challenge of when and how to neutralize a suspect vehicle during the arrest of an occupant.

While the Bureau-wide training was a creditable and important remediation to an identified performance issue, the poor positioning tactics

of Officer Pierce are not addressed in either the Review Board or Bureau's review and disposition.

In numerous prior reports,¹⁰ we have discussed our recommendation that the PPB deadly force review process to require those involved in reviewing member conduct (IA, the Police Review Board, and the Chief) to evaluate officer decision-making prior to the use of force. If that structure had been in place here, those decision-makers would be required to evaluate Officer Pierce's tactical decisions that placed her in the position where she felt compelled to use deadly force.

This incident is another example – similar to those we cited in prior reports – of the gap between the insights produced by the Bureau's Training Division and the accountability of officers for mistakes in tactics or decision making that can be quite influential to the outcome of a given incident. While the Training Division Review was appropriately critical of officer positioning here, that critique did not result in any accountability or remediation for the involved officer. Because the Bureau has resisted evaluating pre-shooting conduct, there is no formal identification of tactical deficiencies or remediation for poor decision-making – a disconnect that is particularly glaring in a case like this one.¹¹

In this case, the Training Division exercised timely and appropriate initiative in developing further training at the Bureau-wide level.¹² But perhaps because the review process does not formally consider officer performance prior to the shooting, there was no formal effort to provide remediation to the involved officers. In this case, at a minimum, the two involved officers should have been debriefed on the shortcomings of their communication and the failure to take time to develop a safer apprehension plan. And Officer Pierce should have been debriefed on the

¹⁰ Fifth Report, Recommendation 20; Sixth Report, Recommendation 34, Seventh Report, p. 86-87, Eighth Report, p. 81.

¹¹ The Bureau's painstaking review of post-shooting decision-making by responding supervisors is a marked contrast. That exercise has definite value, but in our view is substantively less significant than pre-shooting conduct that may contribute to the eventual use of deadly force.

¹² It is unclear whether that training addressed the identified failure of the responding officers in this case to communicate more effectively and develop a sounder custodial plan at the outset of the encounter.

poor tactics she displayed which led to the use of deadly force.¹³ The Bureau's continued lack of effective intervention for cases in which pre-shooting conduct places officers in jeopardy will increase the likelihood that these mistakes will be repeated in future situations. We repeat here our formal recommendation from our Fifth Report (February 2018) (Recommendation 20):

RECOMMENDATION 1: The Bureau should modify its deliberative protocols so that the review of every officer-involved shooting includes an explicit review of pre-shooting tactical decision making, and express findings from the Commander and Police Review Board on whether officers' tactical performance was consistent with training and policy.

The Decision to Use Deadly Force

As detailed above, while the Training Division Review was critical of the involved officer's positioning of her vehicle, it found that the decision to use deadly force was reasonable considering the dangerous position that she placed herself in. OIR Group respectfully disagrees with this opinion. Even though the officer became pinned when the truck advanced, there was no evidence that the firing at the subject's vehicle did anything to improve her situation.

The officer reported her belief that by firing her gun, it caused the driver to stop accelerating and provided her time to jump into her car, but the video evidence does not support that view. In fact, Training notes that it was an additional nine seconds after the shots were fired before the officer re-entered her car. Moreover, as noted above, Mr. Dahlen believed he was being fired upon by the officer behind him, which if anything, would have caused him to be more aggressive in getting away from the officer positioned there and increased the jeopardy of Officer Pierce who was pinned in front. And had the officer been successful in disabling Mr. Dahlen, it may have caused the truck to move even more erratically and dangerously, increasing the danger to her instead of eliminating it. In short, as with many cases involving shots fired at a moving vehicle, the

¹³ As noted above, Officer Pierce was significantly injured as a result of this incident, but any intervention could have been delayed until she was prepared to return to work.

use of deadly force proved ineffectual and was ill-considered. For those reasons, the Bureau should have found that Officer Pierce violated its “Shooting at Vehicles” policy.

Post-Incident Scene Management

As detailed above, the Training review noted that two Acting Sergeants first responded to the scene and were apparently not aware of the need to designate someone as the Incident Commander. Training attributed this lack of understanding to a lack of training and/or experience. As detailed above, both the Training Division Review and the Review Board developed recommendations designed to address this issue. However, there is no evidence that these recommendations were implemented or even fully considered by the Bureau.¹⁴ Moreover, there is no indication that the Acting Sergeants were ever provided post-incident training on scene management and the critical importance of designating an Incident Commander.

¹⁴ To address these concerns, we received notation that the then-Chief requested they be included in a Supervisor’s Guide for officer-involved shooting, which was eventually completed.

March 31, 2021 ◦ Tai Tran

The subject in this incident, Tai Tran, was allegedly involved in a confrontation with an acquaintance that led to his shooting at the other person. Mr. Tran then took that person's truck and drove away. PPB officers located the vehicle and attempted to detain him, but Mr. Tran fled from them in the truck. After a brief vehicle pursuit that included the deployment of a spike strip, the truck crashed into a fence in a parking lot.

Mr. Tran refused to exit the vehicle and made it clear to responding officers that he was armed and did not intend to surrender. This "barricaded subject" situation prompted the initiation of a SERT ("Special Emergency Reaction Team") deployment as well as a response by the Crisis Negotiation Team. A lengthy standoff ensued, as several PPB special vehicles pinned the truck into place to ensure that it was unable to move. Robotic devices were used to monitor him with a camera.

Efforts to resolve the situation through negotiation proved unavailing. Mr. Tran was described as being extremely animated, and at one point was reportedly smoking multiple cigarettes at the same time. He made multiple threats to shoot officers and claimed to have two hostages in the truck – an assertion that was not given significant credence but that reflected a disinclination to surrender. At one point, he fired a shot inside the cab, seemingly to further persuade officers that he was a threat. He also began to occasionally point the weapon at his own head and chest.

The negotiations were not seeming to progress. At one point Mr. Tran made efforts to obscure people's view of him by attempting to cover the windows and windshield of his vehicle. He refused the offer of a fresh phone as delivered by a robot. PPB personnel formed the impression that he was suicidal, and intending either to provoke the police into shooting him or to take his own life.

Given the lack of compliance and the negative direction of efforts to engage with Mr. Tran, the SERT supervisors eventually shifted to discussing and then choosing a tactical plan in which they would attempt to "pressure" Mr. Tran into exiting by introducing gas into the cab of his truck and using a light-sound diversionary device outside the truck to further disorient and distract him. An armored vehicle was also assigned

with the plan to make low speed contact with the truck as a further disruption. Various contingencies in terms of his possible responses were considered and planned for as communications and negotiation attempts continued.

Officers then transitioned from negotiation into commands and warnings. These also failed to provoke a response from Mr. Tran, who had stopped communicating. Ultimately, after approximately four hours of engagement with Mr. Tran, officers initiated the tactical plan.

At some point as the gas and other measures were being deployed, Mr. Tran shot himself with his own firearm. He was eventually declared dead at the scene when PPB personnel were able to safely approach and evaluate his condition.

As a technical matter, the force deployed by SERT personnel was not the cause of the Mr. Tran's death; his suicide was. (Nor was he "in-custody" – a point that was emphasized in the Reporting Unit Manager's memo and presumably contributed to the concision of that document.) The Bureau's internal investigation nonetheless took a formal look at three aspects of the incident.

The first was the use of less lethal force by each of the three officers who deployed it as part of the plan to extract Mr. Tran. These were Officers Joshua Faris and Charles Asheim (who separately introduced gas into the truck), and Detective Brad Clifton (the driver of the armored vehicle that intentionally collided with the truck). In light of the findings that these actions were conducted correctly, at the direction of supervisors, and with legal justification, the Bureau found the use of force to be in policy.

The Bureau likewise found the supervisory response – including the planning and decision-making throughout the lengthy course of the standoff and the final tactical engagement – to be in policy. Finally, the Bureau also found supervisors' performance in applying post-incident response protocols for an in-custody death to be in policy.

The Police Review Board concurred with each of these outcomes.

OIR Group Review and Analysis

This case exemplified a particularly challenging situation for law enforcement: a stalemate with an armed, agitated, and barricaded subject who had shown a very recent propensity for violence. Obviously, there was a nexus here between the SERT shift to a more aggressive tactical option and Mr. Tran's suicide. The question to which we therefore direct focus is whether the choice to disrupt the status quo at that particular point in the proceedings – and thereby prompt an outcome that was certainly possible if not likely – was reasonable.

We agree with the various findings that it was. During the course of the roughly four hours that the barricade lasted, the responding personnel had been methodical in assembling and staging appropriate resources and making concerted efforts to effectuate a peaceful surrender. This included not only the armored vehicles, robots, and weaponry, but also the Crisis Negotiation Team (CNT) members who worked assiduously to de-escalate and engage.

The CNT also brought their expertise and experience to bear on the evaluation of Mr. Tran's actions over time. These observations were reflected in the accounts they offered during the interviews for both the criminal and administrative investigations.

They recognized that the situation was precarious from the beginning, based in part on the behavior that precipitated the call for service, as well as Mr. Tran's continued possession of a gun that he had used earlier that night. Mr. Tran's unstable behavior at the barricade scene, his efforts to provoke police with a false "hostage claim" (that he fired a shot in order to perpetuate), and the suicidal nature of many of his gestures (including pointing his gun "carelessly" at himself at various junctures) reinforce this impression.

Interactions were handled methodically, and the PPB personnel showed a willingness to try different techniques in an effort to convince Mr. Tran to surrender. Unfortunately, they not only failed to work, but seemed less effectual as the standoff continued. At one point, Mr. Tran agreed to put his weapon on the dashboard but then reneged, placing a different black object there as if intending to fool the police. The devolution into Mr. Tran's rejecting communication and attempting to shield himself from view led negotiators to determine that achieving compliance had ceased to be a

likely path toward resolution.¹⁵ In other words, the passage of time had not enhanced the likelihood of a voluntary end to the incident, and had arguably lessened it.

Officers and supervisors carefully deliberated and weighed their options before shifting to the tactical operation. They discussed different strategies and force options in an effort to evaluate which was most likely to achieve the desired results of getting Mr. Tran out of the vehicle and separating him from his weapon. That plan was then executed correctly. That it did not lead to successful outcome is unfortunate but not determinative of its soundness in this difficult context.

Training Division Review

Following its usual protocol, the Training Division reviewed the entirety of the incident and found that the actions within each phase were “within a reasonable range of options and tactics.” It also identified three areas for further consideration.

The first related to the post-incident monitoring of involved personnel. There was some indication that SERT members were not relieved from their positions for some time; nor were they separated or advised of impending interviews until after they apparently had the opportunity to meet as a group. This circumstance was not believed to be malicious or any attempt to compromise investigative integrity; instead, it was probably a function of the incident’s unique characteristics. But it did prompt a recommendation from Training that a protocol be refined for addressing separation and admonishments in the context of large-scale events.¹⁶

The second Training recommendation related to the advisability of a backup contact from the Bureau’s Enhanced Community Safety Team. Apparently, the on-call sergeant did not initially respond to repeated attempts at contact as the incident was unfolding. That individual

¹⁵ One of the interviews of involved supervisors cited the agreement of a clinical psychologist who worked with PPB as part of the CNT unit and was on scene.

¹⁶ It does not appear that this issue – which potentially reflected a shortcoming in compliance with post-incident investigative protocols at the scene – was addressed administratively with Sergeant McConnell. This may have been a function of his retirement during the pendency of the investigation.

ultimately responded and provided the requisite assistance, but the difficulty did highlight the advantages of having a “Plan B” for overcoming future communications obstacles.

Lastly, the Training analysis underscored one of the points made by witnesses to the investigation: namely, the burden that lengthy deployments can potentially place on members of specialized units when no relief is available for extended periods.¹⁷ It was recommended that the City look for ways to encourage surrounding agencies to overcome liability and risk concerns and increase their willingness to provide mutual aid in these unusual situations. As we say elsewhere in this report, the importance of acknowledging, formally accepting, and developing implementation plans for each Training recommendation cannot be overstated.

¹⁷ The Training memo made reference to one recent callout that had extended for some 24 hours.

May 21, 2021 ◦ Darrin Carr

Officers Colby Marris and Jenna Lemke, working as partners in one patrol car, responded to a report of a stolen truck. The officers observed a parked vehicle which was the same model truck but a different color. Officer Lemke queried the license plate on her mobile digital computer and learned this truck was also reported stolen. She then broadcast this information so that other units could respond, and Officer Marris turned their car around to make contact. As they approached, Officer Marris noticed that the headlights of the truck were on but did not see anyone in or next to the vehicle. Officer Lemke said she had observed a subject standing next to the open driver door of the truck.

Officer Marris parked so that the patrol vehicle was partially in the roadway but mostly in front of the truck and activated the car's overhead emergency lights and takedown lights. Officers then saw a driver (later identified as Darrin Carr) suddenly drive forward into their patrol car. Officer Marris then also drove forward while Mr. Carr placed his truck into reverse, and the patrol car kept in contact with the front bumper of the truck. The truck hit a parked trailer and continued backward while the patrol car stopped at the edge of the roadway.

The officers saw the driver's door of the stolen truck open, followed by the subject getting out and briefly disappearing. The officers got out of their car with the belief that the subject was likely fleeing on foot. However, Mr. Carr got back into the truck and started driving backward and forward. His partner moved to avoid getting hit by the truck.

Both officers had their handguns drawn and gave commands as the truck repositioned. Officer Lemke again moved to the passenger side of the patrol vehicle. Officer Marris reported that Mr. Carr then drove directly at him, leading him to move out of the truck's path while firing eight rounds at the driver. The truck then drove away at a high rate of speed.

Mr. Carr was apprehended at another location after the truck crashed following a vehicle pursuit and the use of spike strips.¹⁸ Mr. Carr received medical aid for gunshot wounds to both of his arms and right wrist.

The Grand Jury heard the case against Mr. Carr and, as a result, criminal charges were filed against him. The District Attorney advised the handling PPB detective that “relying on the same body of evidence, the Grand Jury considered the question of whether the force used by Officer Marris was justified under Oregon law.” The DA reported that with respect to the criminality of Officer Marris’ use of force, the Grand Jury returned a not true bill.

The Bureau found the shooting to be in policy. The Reporting Unit Manager, Police Review Board, and Chief all concurred, and recommended that the Training Division use the post-incident response as a case study for training purposes, as all believed that it was an exemplary model of how to coordinate across multiple scenes.¹⁹ The Board further recommended that the Training Division provide clarification about when it is appropriate to use a single vehicle “box-in” technique and when it is safe to use a parked vehicle as the other half of the box-in.²⁰ The Board also recommended that the Bureau improve the mechanisms for supervisors to make appropriate notifications following officer-involved shootings.²¹

OIR Group Review and Analysis

Training Division Review

The Training Division Review found that the involved officers’ initial response involved driving by the truck, making observations, and gathering information, including broadcasting the stolen vehicle status to other area units. It recognized that the two officers had been working

¹⁸ The vehicle pursuit was not evaluated as part of the deadly force review.

¹⁹ The Training Division advised that this incident was incorporated into its curricula.

²⁰ While this recommendation was listed as a task in the Bureau’s “need assessments,” there is no further indicia that this task was ever accomplished.

²¹ The Bureau reported that this recommendation was implemented when the OIS supervisory guide was completed.

together and found that better direct verbal communication about their plan and the subject's location in relation to the truck would have been beneficial in executing the plan and adapting to contingencies.

Training also found that as officers were first executing their plan, they did not anticipate the subject's decision to drive into their patrol vehicle. The analysis found that Officer Marrs "adapted" by also driving forward to match the truck's forward motion. When the subject placed the truck in reverse, Officer Marrs saw an opportunity to attempt a single vehicle "box-in" by driving the truck into a parked travel trailer and trying to hold it in place with the patrol vehicle. Mr. Carr was able to thwart the box-in attempt by turning the truck's steering wheel.

Training credited Officer Marrs for remaining adaptable, trying to maintain the advantage by continuing front bumper contact to drive the truck off the roadway and causing it to become stuck in the field. Officers observed the driver door of the truck opening, indicating that Mr. Carr was likely fleeing on foot. Training noted that in response, and "without communication" the officers chose to exit the patrol vehicle.

Once Mr. Carr reentered the truck, both officers drew their firearms and shouted commands, which Training acknowledges may not have been heard due to the revving engine of the truck. Officer Lemke moved to the passenger side of the patrol vehicle for better cover. Training concluded that Officer Marrs fired multiple rounds at the truck as Mr. Carr drove in his direction while simultaneously trying to move out of the path of the approaching vehicle.

In addition to making recommendations regarding staffing, the Training review recommended that future in-service training sessions revisit the subject of effective officer communication when forming plans and verbalizing important observations that might lead to changes in those plans. The review also recommended updated training on considerations and tactics related to the decision to shoot at moving vehicles.

Attempting to Box-in a Moving Vehicle

The Training Division Review considered the unique situation where Officer Marrs attempted to "box in" a moving vehicle. The "box in" technique is ordinarily applied to a stationary vehicle to prevent it from

driving off and usually involves the use of two patrol cars. In this case, the subject's truck was moving in reverse when Officer Marris tried unsuccessfully to use a tractor trailer and his patrol car to "box in" the subject's truck and then tried to push the truck into an adjacent field, neither strategy being successful. As noted above, the Police Review Board specifically recommended that the Training Division evaluate the efficacy of using a parked vehicle to accomplish the "box-in" technique. We agree with the Board that this approach (which proved unsuccessful) should be evaluated by the Bureau's training experts regarding its usefulness.

RECOMMENDATION 2: The Training Division should evaluate the efficacy of using a parked vehicle as part of a box-in technique and update its training curriculum accordingly.

Analysis of Bullet Strikes on the Subject's Vehicle

In his interview with Internal Affairs, Officer Marris said that he was approximately 10 feet from the truck when he discharged his firearm. He stated that he saw a "giant truck grill" coming right at him. Officer Marris said he did not see where his bullets struck the truck. Officer Marris said he continued to fire until he felt his life was no longer in danger. Officer Marris said he recalled seeing the passenger window shatter and fall into the street from his gunshot, which he believed was the last round he fired.

As part of the criminal case against Mr. Carr, Officer Marris testified to the Grand Jury that he thought he was about five feet away from the truck when he fired for the first time and that he was in front of the truck when he did so. He said he was backpedaling as he continued to fire. Officer Marris testified he stopped firing when he saw the driver duck and the direction of the truck change. Officer Marris testified, that there was no pause in between the rounds being fired, and that there was no point earlier in the sequence where he felt it would have been safe to stop firing.

Detectives wrote that an examination of the involved truck showed one bullet strike to the front passenger side bumper, three bullet strikes to the passenger side A pillar, and two bullet strikes to the passenger side door. The detectives wrote that the passenger side window appeared to have been shattered and there was a bullet strike on the inside of the driver's side door.

A photograph of the truck taken by PPB's forensic team showed the side bullet strikes and is consistent with the Detectives' description.



The bullet strike evidence does not reconcile with Officer Marris' statement that he was in front of the truck when he fired his rounds. Instead, the bullet strike evidence suggests that all of Officer Marris' rounds struck the side of the truck or the side of the truck's front bumper. Particularly concerning are the two bullet strikes to the truck's passenger door and the strike that shattered the passenger window. Bullet trajectory analysis was performed by detectives in an effort to determine where the shooter would have been standing when he fired. However, when Officer Marris was questioned by Internal Affairs, he was not presented with the bullet trajectory analysis nor asked to explain the discrepancy between his account and the bullet strike evidence. Moreover, mere observation of the

strikes strongly suggests that Officer Marrs was positioned to the side of the truck when he fired his rounds.²²

The Bureau did not sufficiently address this issue in its internal administrative review. Certainly, an officer who is positioned to the side of the truck is not in imminent harm's way from the truck. And even if the round to the side of the front bumper and the one's to the pillar suggest a positioning more toward the front of the truck, the apparent final three rounds do not reconcile with the officer then being in a position of imminent danger.

Officers are trained that they are responsible for every round they fire and that they should stop firing when any perceived threat has dissipated. In this case, Officer Marrs was not presented with the bullet strike evidence, nor was he asked about his ongoing perception of threat as it related to the shots that struck the front passenger window and front door panel. It was a serious shortcoming in the Bureau's administrative investigation and reviews of the incident.²³

RECOMMENDATION 3: Where photographic or forensic evidence conflicts with an officer's account of the incident, the Bureau's investigation should examine and ask the officer to explain any potential discrepancy.

²² As indicated above, Officer Marrs stated that he saw the passenger window shatter when he fired his last round.

²³ We note that in some of the other cases we reviewed for this report, the IA investigation includes a section that specifically discusses and evaluates any discrepancies in testimony or evidence.

July 20, 2021 ◦ Joshua Merritt

Just after 9:30 PM on July 20, 2021, the owner of a convenience store called 911 to report that a person, later identified as Joshua Merritt, was acting erratically, had eaten food without paying, and was refusing to leave the store. The owner reported that the person had told him to call the police.

Officers Craig Lehman and Douglas Dickinson were both dispatched to handle this call. Officer Lehman arrived first and waited outside for Officer Dickinson to arrive. He observed Mr. Merritt through the window, just sitting at the end of one of the racks and seemingly relaxed and minding his own business. The officers entered the store together and Mr. Merritt immediately got up and moved to the back of the store. They immediately heard glass breaking and the owner reported Mr. Merritt had broken a wine bottle. The owner then left the store.

Officers observed Mr. Merritt raising a different wine bottle, seeming to gulp down its contents, and realized this event may be more complex than a simple “unwanted person” call. Officer Lehman recognized that the subject might have been under the influence or in some type of mental health crisis and asked dispatch to page medical and have them stand by.

Officers stood at one end of the store’s center aisle while Mr. Merritt was at the other end of the aisle, in a puddle of red wine. Officer Lehman asked him to put down the wine bottle, in what he described as a conversational, low-key tone. Mr. Merritt responded something like, “Let’s do this, motherfucker!”²⁴ He put down the bottle he was drinking from but then officers realized that he held in his other hand a piece of a broken wine bottle. Officer Lehman withdrew his handgun and held it in “low

²⁴ Officer Dickinson remembers Mr. Merritt using a different phrase, also containing profanity. The difference is inconsequential here, though it does highlight the absence of body-worn cameras and the clarity around these details the video footage provides.

ready.”²⁵ He ordered Mr. Merritt to drop the bottle and warned that he could get shot.

Following the warning, Mr. Merritt rushed at the officers, with the broken bottle raised at shoulder level. When he was approximately 5-10 feet away from the officers, Officer Dickinson fired his Taser. Officer Lehman heard the Taser deployment and almost simultaneously fired his handgun. He struck Mr. Merritt in the thigh. Mr. Merritt dropped to the ground, holding his leg while also pulling the Taser probes from his chest. He then got partway up and began to move away from the officers, toward the back of the store. Officer Dickinson fired a second cartridge from his Taser with the intent of stopping Mr. Merritt’s retreat and getting him to drop the bottle so officers could safely take him into custody. This second Taser use appeared not to have any effect on Mr. Merritt.

Mr. Merritt sat down at the back of the store and consumed a canned beverage while the two officers stayed at the front of the store, monitoring him and waiting for backup.

A sergeant and other officers arrived and entered the store within four minutes of the shooting. They formed a custody team and approached Mr. Merritt, securing him without incident. Medical personnel were cleared to enter the store and began treating Mr. Merritt’s wound within nine minutes of the shooting. The bullet wound was not life-threatening. He was released from the hospital the next day.

The shooting incident was captured, without audio, on the store’s security camera.

When questioned by Detectives, Mr. Merritt said he asked the store clerk to call police so he “could have suicide by cop.” He said his plan was to scare officers so they would shoot. Once shot, he stated he refused to obey commands and was trying to “hold out” long enough to die.

The District Attorney determined that a grand jury review was unwarranted. The DA instead issued a memo summarizing the facts and

²⁵ “Low ready” refers to unholstering the gun but holding it down, either in front or to the side, not pointed at any target but allowing an officer to be prepared to engage more quickly if needed.

applicable law and concluding the evidence established that Officer Lehman was legally authorized to use deadly force in this incident.

Mr. Merritt was charged with menacing and unlawful use of a weapon. He ultimately pled guilty to the weapon charge and was sentenced to probation.

The Bureau and the Police Review Board both concluded that officers' and supervisors' actions were in policy. The PRB made two recommendations. One was to provide dispatchers training on best practices around information conveyed to officers that might be helpful in "situations that could be perceived as suicide-by-cop scenarios."²⁶ The then-Deputy Chief declined to adopt this specific recommendation because the PPB is not responsible for training Bureau of Emergency Communications (BOEC) dispatchers. However, he modified the recommendation in an effort to convey its intent: "The BOEC liaison sergeant will discuss with BOEC ways to enhance information gathering during the call-taking phase that would increase safety." It is not clear from the documentation we received whether this discussion occurred.

The second recommendation from the PRB was for the Bureau to increase staffing to three sergeants per shift to ensure supervisory presence in cases such as this one. On the day of this incident, there were three sergeants working, though one was serving as an Acting Lieutenant covering vacation leave. The then-Deputy Chief declined to adopt this recommendation. He cited the specific supervisory staffing requirements, tied to span of control, dictated by the Settlement Agreement with DOJ; he also noted that the Bureau has systems in place that generally result in having three sergeants working per shift.

²⁶ We have been critical in the past of law enforcement's use of the phrase "suicide by cop" and noted the Police Review Board's use of it here. We discuss this dynamic in the Common Issues section of this report.

OIR Group Review and Analysis

Planning and Communications

Officer Lehman was the primary assigned officer, and he arrived on scene first. He waited outside the store for backup while positioning his patrol vehicle so he could see inside the store. Some people were coming out of the store, seemingly unalarmed, and Officer Lehman could see Mr. Merritt sitting calmly and not posing a threat to others. When Officer Dickinson arrived, the two officers approached and entered the store, without any discussion or planning. They were both questioned about this during their respective interviews, and both stated they viewed this as the type of call they handle frequently, and it was clear to both what their roles and responsibilities would be, without any express communication.

The Training Division examined this issue in its review and found the officers' approach was consistent with their training. They each had a tacit understanding of the plan that was sufficient for a call of this nature. While taking the time to verbally confirm their understanding would not have negatively impacted the situation, it also would not have changed the response in any meaningful way. As the incident unfolded, each assumed his appropriate role, even as the threat level changed.

Dispatch Issues

One aspect of the communications and planning not addressed by Training was discussed by the Police Review Board: the impact of the communications from dispatch to the officers. Here, the store owner reported to the dispatcher that the man in the store was asking him to call the police. That information was not conveyed to officers. The relevance of this information is obviously easier to see in hindsight than it might have been at the time, but it is worth asking whether knowing the individual in the store requested a police response might have altered officers' approach to the call.

The answer, of course, is neither clear nor definitive. If officers had known Mr. Merritt was asking for police, it is possible they may have recognized this as not "just" an "unwanted person" call by a store owner, but instead as a request for help from a person in mental health crisis. They might have evaluated the possibility of calling in mental health resources or

might have approached their communications with Mr. Merritt differently. Instead of requesting that he leave the store, officers might have tried talking to Mr. Merritt about services that may have been available to him.

A changed approach may not have led to a changed outcome, but the possibilities are nonetheless worthy of exploration. The Bureau understandably pushed back on the PRB's recommendation around training for BOEC dispatchers – BOEC is not within the Bureau's span of control. The Bureau's modified version of this recommendation, though, could have more specifically addressed the relevant issue: the Bureau's ability to work with dispatchers to gain a greater shared understanding of what information may be helpful for officers to identify individuals who may be suffering a mental health crisis, including those who may be seeking to provoke officers to shoot them.

We have discussed issues surrounding the relationship between PPB and BOEC at various times in past reports. Prior recommendations have looked at ways to build more positive communications through joint trainings and the inclusion of BOEC in PPB processes for reviewing critical incidents. We understood that these recommendations had been accepted and implemented. Our recommendation here seeks to solidify and expand on that past work, with a specific emphasis on identifying subjects who are potentially in crisis and seeking self-harm through police intervention.

RECOMMENDATION 4: The Bureau should work with BOEC leaders to develop a training bulletin for dispatchers on recognizing and conveying to officers relevant information about the possibility of a subject seeking self-harm through police intervention.

Simultaneous Use of Taser and Firearm

The Training Division Review discussed at length the officers' force options, noting with approval the way officers (without advance planning) appropriately selected different tools (both lethal and less-lethal) once they identified that Mr. Merritt had effectively armed himself with an improvised edged weapon.

Based on review of the surveillance video, only seven or eight seconds passed between the time officers unholstered their weapons and when they fired those weapons. The officers fired at nearly the same time. Ideally, the less-lethal option – here, the Taser – would be deployed first, with deadly force to follow only if the Taser was ineffective. But Mr. Merritt was just 5-10 feet away when officers fired. At that short distance, Officer Lehman could not wait to see if the Taser would be effective without putting himself and his partner in danger of the significant harm Mr. Merritt could have done with the broken bottle.

Training found both uses of force to be reasonable and consistent with PPB training but also questioned whether Officer Dickinson could have deployed the Taser sooner in this scenario, before Mr. Merritt began rushing the officers. We appreciate the lengthy discussion of this issue in the Training Division Review, which was both comprehensive and illuminating. Training concluded that Officer Dickinson would have been justified in deploying his Taser (Conductive Energy Weapon, or CEW) sooner and further noted: “there is a *possibility* that if the CEW had been deployed sooner, *and if it was effective*, the shooting potentially could have been avoided.”²⁷

This obviously would be a preferable outcome. However, Training also noted that the Bureau has increasingly emphasized to officers the importance of warnings, communication, and de-escalation techniques as ways to avoid the use of force altogether. And this sometimes works, in situations that never come to the attention of the public. It’s impossible to know in advance – or in the moment – which approach will be most successful. As a result, there is no “right” tactical approach in many of these scenarios. Officers rely on their training and instincts to make quick decisions that are later judged on a standard of reasonableness and compliance with training and policy.

Mental Health Concerns

In the days following the shooting, investigators gathered information about Mr. Merritt and the extent of his mental health crisis. Detectives learned that around five hours prior to the shooting, Mr. Merritt had

²⁷ Training Division Review, p. 18. Italics in original.

jumped into the Willamette River. A 911 caller reported he was hanging onto a side wall and appeared unable to get out. Officers were dispatched, along with Portland Fire Bureau. Fire personnel contacted Mr. Merritt in the water and brought him to safety. No PPB officers made contact with him at that point. A day before this shooting incident, Port of Portland Police contacted Mr. Merritt at the airport in response to a call about an “unwanted person” at an airline ticket counter. Mr. Merritt said then he was trying to get back to Arizona but did not have money. The Port officer asked him to leave the airport and he willingly complied.

We note these prior encounters with other law enforcement and with Fire personnel in the day and hours prior to his contact with PPB officers only as an observation. While this background helps to put Mr. Merritt’s actions during the shooting incident into context, it was unknown to the officers at the time. We understand the City has invested significant resources in increasing mental health services and in creating new alternatives for people in crisis since the time of this incident. We do not speculate whether Portland Street Response would have been utilized to provide the type of help Mr. Merritt was seeking and whether an individual in similar circumstances today would avoid a deadly force encounter with police, but we are hopeful that the City’s progress in this arena is leading to changed outcomes.

December 6, 2021 ◦ Brandon Keck

This incident occurred on a weekday morning and ended up involving multiple crime scenes and 40 minutes of ongoing criminal activity before culminating in a fatal officer-involved shooting on a major highway.

PPB officers initially responded to a call for service after a man (later identified as Brandon Keck) went into a private residence and took the keys to the owner's vehicle at gunpoint. From there, a trail of events unfolded as officers attempted to locate and apprehend Mr. Keck, who exchanged stolen vehicles on multiple occasions and fired at least one shot in the course of doing so.

Officers eventually spotted one of the cars stolen by Mr. Keck and a pursuit – which had been pre-authorized by a supervisor during the unfolding incident – was initiated after Mr. Keck failed to yield to an attempted traffic stop. Mr. Keck drove his vehicle at a high rate of speed and then entered a major highway in the wrong direction. Pursuing PPB officers chose to take the opposite onramp and follow in the correct direction while tracking Mr. Keck visually as he went against traffic on the other side.

Mr. Keck was quickly involved in a collision, got out of his car, and began to move along the jammed traffic on foot; officers could see that he was carrying a gun and surmised that he was attempting to secure another vehicle in an apparent effort to escape. Three PPB officers, including Officer John Hughes, were now out of their respective vehicles and trailing him, also on foot. They gave multiple commands that had no influence on Mr. Keck's actions.

Mr. Keck successfully carjacked a final vehicle that had been progressing slowly on the interstate. Two young parents and a small child had been in the car. At that point, Officer Hughes, who was carrying a rifle after leaving his car and who had climbed over the barrier separating the north and south lanes of the highway, caught up with Mr. Keck. He gave additional commands to stop that were also ignored. Aware that Mr. Keck was armed, had committed a number of serious felonies, and was actively disregarding law enforcement, Officer Hughes believed that Keck posed a deadly threat to on-scene officers and the members of the public who

were on the interstate in close proximity. Officer Hughes fired 10 rifle rounds into the driver's side of the slowly moving car. Several of these struck Mr. Keck and incapacitated him, and the vehicle came to a stop.

Officers put together a plan to safely approach, extract him, and render medical aid. His wounds were fatal, however, and he was pronounced dead at the scene.

In keeping with standard protocols, the incident was the subject of both criminal and administrative investigations. The criminal case was presented to a Grand Jury, which completed its work some three months after the shooting and determined that there was not a basis for prosecution of the officer for his use of deadly force.

The Bureau's administrative review had three focal points. It considered the actions of Officer Hughes for his use of deadly force, the supervisors who were responsible during the unfolding incident, and the supervisors who were in charge of the various post-incident protocols. All were found to have acted in a manner consistent with policy and agency expectations. The Commander's recommendations to that effect were endorsed at all levels of the review process, including the Police Review Board (which added several compliments to the involved personnel in its attendant memo).

OIR Group Review and Analysis

This incident posed unusual challenges to which PPB seems to have responded well. Any one of Mr. Keck's individual crimes – beginning with an armed home invasion and including multiple car thefts, assaults, reckless driving behavior and at least one (non-hit) shooting – would have constituted a significant enforcement event. For them to have occurred in rapid succession and across a significant distance meant that PPB needed to be particularly flexible and well-coordinated. It appears that it was.

We found the Bureau's review of the incident to be thorough and well-structured. The officer who ultimately used deadly force described his thought process at length in his administrative interview. His decision-making and rationale for the different steps that he took within a

dangerous, dynamic situation seemed both reasonable and well-supported by other available evidence.²⁸

We also noted favorably his decision to not follow Mr. Keck up the off-ramp and on to the interstate in the wrong direction, instead choosing to parallel his actions from the correct side. The repeated warnings and moments of cautious movement during the foot pursuit portion of the encounter showed the officer's inclination to avoid using his weapon, if possible, while keeping paramount the safety of obviously endangered members of the public.

Training Division Review

The Training Division Review was an excellent contribution to the Bureau's overall review of this incident. Its affirmation of the involved Bureau members' handling of the different elements of a complex event was itself informative and persuasive.

The analysis was complimentary of the initial elements of the Bureau response, particularly insofar as it required officers and supervisors to piece together a rapidly evolving event in real time. Identifying the different, sequential criminal actions by Mr. Keck as being related happened efficiently, even across multiple precincts within the city.

As for the deadly force itself, the Training Division determined that it was consistent with policy, training, and expectations. Multiple warnings and efforts to prompt Mr. Keck's surrender were ignored; instead, his efforts to escape intensified as he stole another car from its occupants.

Firing at a moving vehicle is itself a distinctive category that carries its own restrictions; the analysis found that the shooting was warranted in light of the overall circumstances. These included Mr. Keck's armed status, the fact that he had shot at someone earlier in the incident, and the fact that the recklessness of his observed driving behavior was itself a threat to other motorists. The analysis noted the efforts by officers on the interstate to use cover and other tactical advantages where possible, and described the backdrop of the multiple rounds as multi-layered and well-suited to

²⁸ This included multiple eyewitness statements and a cellphone video that captured the moment of the shooting itself, and which corroborated the shooting officer's account.

prevent accidental injury to third parties. The officers also moved swiftly to develop a safe plan to approach and render medical aid to Mr. Keck, whose injuries were visible.

As for the different supervisors involved in the incident, the Training Division Review described their respective roles and found that they had, too, had acted in a manner consistent with expectations. They coordinated well with each other in terms of dividing responsibilities and addressing the contingencies of a complex event.²⁹

The Training Division provided two recommendations. The first was simply an encouragement for the Bureau to direct managerial attention to the training of “complex expanding mobile incidents” such as this one, which place unique demands on law enforcement and fall into the category of “high risk/low frequency.”

The other was a specific response to one of the dynamics in this case. One of the involved supervisors had vacillated as to activating the Bureau’s Special Emergency Reaction Team (“SERT”) personnel. He ultimately decided against, under the theory that the mobile nature of the incident rendered it ill-suited. (The team would have lacked a set staging area, for example.) The Training analysis demurred from this contention, and recommended that the Bureau provide information to all patrol sergeants about SERT capabilities as a resource in situations like this.

²⁹Examples of the distinctive tasks included sealing off highway traffic and arranging a bus for the many eyewitnesses to the event.

December 11, 2021 ◦ Joshua Degerness

On the date of the incident, Acting Lieutenant Norman Staples was overseeing a law enforcement initiative focused on locating and recovering stolen vehicles. Thirty officers were dedicated to this effort according to the incident action plan.

Officer Kenneth Jackson attempted to conduct a traffic stop for expired vehicle registration. The vehicle eluded the officer who chose not to pursue with emergency equipment. However, approximately one minute later, the officer performed a Pursuit Intervention Technique (“PIT”)³⁰ on the vehicle that had initially eluded him, causing the vehicle to crash into a tree.

Officer Jackson broadcasted about the PIT after the fact and additional officers arrived to assist. Officers instructed the man, later identified as Joshua Degerness, to put his hands up but Officer Jackson observed Mr. Degerness reaching underneath his seat and broadcasted this information. Mr. Degerness refused to exit the vehicle despite officers’ instructions. It was initially unknown whether Mr. Degerness was trapped or injured as a result of the crash (and thus unable to exit) or was being non-compliant. Mr. Degerness began to yell profanities and yelled at officers to “come up and get me.”

Acting Lieutenant Staples and two sergeants arrived on scene. They attempted to communicate with Mr. Degerness for approximately six minutes, which proved to be unsuccessful as Degerness was non-compliant, antagonistic, and refused to exit the vehicle.

Officers and sergeants on scene then used Officer Jackson’s car as cover and moved to a position where they could deploy OC (pepper spray) into the vehicle in an effort to gain compliance from Mr. Degerness. After a sergeant deployed the OC, Mr. Degerness pointed a handgun and fired at the officers. Acting Lieutenant Staples and Officer Jackson returned fire, striking Mr. Degerness.

³⁰ A PIT maneuver is a law enforcement pursuit tactic used to stop a fleeing vehicle by making physical contact that causes the subject vehicle to spin out and stall.

Recognizing that Mr. Degerness had been hit, the officers requested medical aid. They also ultimately activated the Special Emergency Reaction Team (SERT) and the Crisis Negotiation Team (CNT) as additional resources.

CNT and SERT responded. CNT negotiations proved unsuccessful. SERT deployed a chemical agent to the interior of Mr. Degerness' car using a robot. Mr. Degerness continued to refuse to exit the vehicle. SERT then removed Mr. Degerness from the vehicle. Mr. Degerness was found sitting on a handgun. Once Mr. Degerness was removed by being pulled from the vehicle, he was immediately provided with medical care by on-scene SERT medics and then transported to the hospital. It was later determined that Mr. Degerness sustained a single gunshot wound to his left shoulder, an injury he survived. He was later prosecuted for attempted murder. Again, the District Attorney chose not to have the Grand Jury consider the deadly force used by Bureau personnel.

Both IA and the Reporting Unit Manager recommended that all decisions relating to the use of force operational planning, and post shooting procedures be found in policy, with a debriefing to Acting Lieutenant Staples regarding his failure to assume the Incident Commander role and assign tactical responsibilities to other personnel. The Assistant Chief controverted the proposed finding as to the acting lieutenant, instead determining that Acting Lieutenant Staples' failure to assume the role of Incident Commander violated Bureau policy.

The Assistant Chief also went further in his analysis of the incident, in a memo that was more detailed and substantive than other Chief's memos we reviewed. He indicated concern about the amount of time between the PIT and shooting and opined that more time was warranted to talk to Mr. Degerness and perhaps page a SERT sergeant for a consult prior to making their approach. The Assistant Chief also identified tactical concerns and issues that could have been better resolved prior to implementing the plan and that could have been alleviated had there been an Incident Commander in charge of the operation who was not also involved in tactical actions. The Assistant Chief also noted that it would have been helpful for IA investigators to have asked officers who they understood to be in charge during the incident.

The Deputy Chief noted that the Police Review Board recommended that the Training Division consider developing lesson plans for greater accountability for supervisors acting in the role of Incident Commander. The Deputy Chief further noted that the PRB agreed with the training recommendations in terms of pre-emptive PIT's and using OC pepper spray to force an unwilling participant out of a vehicle and that the Training Division should provide more guidance on contingencies for subjects who refuse to get out of a vehicle. The Chief's memo adopted all the recommendations and requested that they be assigned to the Training Division for inclusion in their training needs assessment. He recommended that these points should be emphasized at all levels of training so that they become part of institutional thinking and culture.

OIR Group Review and Analysis

In this case, the decision to use deadly force was appropriate considering the threat presented when Mr. Degerness pointed and then fired his gun at responding PPB personnel. However, as PPB itself recognized, there were other decisions made by responding officers that were worthy of critique, reconsideration, and potential interventions.

Training Division Review

The Training Division Review identified a number of issues with the supervision of this incident, including:

- The Acting Lieutenant incorrectly surmised that this incident was not a critical incident as defined by Bureau policy and found that he should have recognized the need for an after-action review.
- There was adequate time for the Acting Lieutenant to prioritize his supervisory role and avoid direct tactical involvement. He should have assigned himself as the Incident Commander and requested one of the many officers assigned to the mission to take over the tactical role he had assumed. His decision not to was counter to PPB training and policy.
- The on-scene supervisors failed to discuss who would be the Incident Commander.

The Training Analysis found that the Acting Lieutenant's decision was counter to PPB training and Directive 315.30.

The Training review also found that Officer Jackson's decision to implement the PIT maneuver without prior communication was reasonable even though it noted that a PIT in most cases should be planned and communicated to ensure there are adequate resources to support post-PIT actions.

The review also recommended that the Training Division should provide more specific guidance on contingencies for subjects who refuse to exit a vehicle.

The Training review noted that there was nothing in the case materials that suggested it was necessary to remove Mr. Degerness from the car after just six minutes. Training noted that interviews with on-scene personnel provided no insight about why they decided against providing Mr. Degerness further opportunity to comply.

Finally, Training noted that there was nothing in the case materials that spoke to whether a CNT/SERT consult was considered as an option prior to the deployment of OC spray.

The Extemporaneous PIT Maneuver

As detailed above, when the vehicle he attempted to pull over instead drove away, Officer Jackson recognized that the suspected violation and circumstances did not justify going into vehicle pursuit. Nonetheless, Officer Jackson decided to intentionally strike the vehicle, causing it to crash into a tree. Using a patrol car to strike a vehicle is a significant use of force with potential safety issues for the officer and subject alike. In our experience, we have seen PIT maneuvers leading to serious injury or even death. Moreover, as PPB itself recognized, executing a PIT without notice or supervisory approval runs the risk of a single officer having to deal with the aftermath of the crash without sufficient resources.

As a result, a number of agencies require that officers notify and obtain authorization before executing a PIT maneuver. For the same reason that vehicle pursuits require communication and oversight by supervisors, a non-involved supervisor is in a better position to weigh the "risk vs. reward" of engaging in such a maneuver and can better ensure a

thoughtful response that fairly weighs competing concerns.³¹ For these reasons, PPB should develop a policy requiring that officers notify and obtain approval from a supervisor before engaging in a PIT maneuver.

RECOMMENDATION 5: The Bureau should modify its directives and training to require that an officer seek and obtain approval from a supervisor before engaging in a PIT maneuver.

Concerns about Tactical Decision-making

As detailed above, Internal Affairs, the Training Division Review, the reviewing Commander, the Police Review Board, and the Assistant and Deputy Chiefs all identified sub-optimal decision making in this incident, including the following:

1. The failure of the acting lieutenant to assume role of Incident Commander and assign tactical responsibilities to others
2. More efficacious strategies to extract unwilling persons out of vehicles
3. The need for supervisors to designate an individual as Incident Commander
4. The determination to extract the subject from the vehicle after only six minutes of communication when there was no apparent exigency to do so
5. The failure to consider consulting with a SERT supervisor prior to effectuating the attempt at extraction which did not succeed and resulted in a deadly force incident
6. The need for the Incident Commander to avoid assuming a tactical responsibility and to retain a supervisory role³²
7. The apparent lack of certainty regarding each on scene officer's role

³¹ As noted above, the initial traffic violation was for an extremely low-level offense: expired registration.

³² We were heartened by the concerns registered relating to this issue as we have repeatedly identified supervisors assuming tactical roles in past incidents. It is particularly creditable that the then Deputy Chief determined to hold the acting lieutenant accountable for this violation of policy.

8. The failure of Internal Affairs to ask on scene officers who in their view was in charge of the scene prior to the use of deadly force

While most of these issues were assigned to be addressed by the Training Division, there is no evidence from the files that each (or any) were adopted and implemented. When we made further inquiry, we were advised that Bureau recommendations 1, 3 and 6 was considered already implemented by prior training. There is no apparent documentation with regard to any of the other recommendations. We reiterate our recommendation to ensure that there be more deliberate consideration and documentation of Bureau-derived recommendations.

August 16, 2022 ◦ Robert Connelly

PPB's Focused Intervention Team put together an operation (in coordination with other units, for a total of some 15 members) that was designed to apprehend a subject, Robert Connelly, who had multiple warrants for his arrest. Several team members conducting surveillance spotted Mr. Connelly as he left a motel on foot. Following the pre-established plan, two "partner cars" (with a total of three officers and a supervisor) attempted to make contact and take him into custody, but he immediately ran from them.

After a brief foot pursuit that involved the supervisor (Sergeant Charles Elam) and two officers (Christopher Baten and Amy Li), Mr. Connelly cut through a small parking lot and entered the open garage bay of a mechanic shop where workers were attending to vehicles. Connelly turned and pointed a firearm at the pursuing members of the arrest operation. All three responded by firing multiple rounds each at Connelly, who was not struck.

Mr. Connelly then entered the office portion of the mechanic business through a side door. He remained there for approximately 90 minutes with a customer who had been in the building waiting for his car and effectively became a hostage. Meanwhile, PPB brought additional resources to the scene in an effort to safely resolve the standoff.

During this time, Connelly communicated by phone with a female friend, interacted with the customer, ingested drugs that were in his possession, and eventually surrendered. He was taken into custody without additional force.

Because Mr. Connelly had not been wounded, the PPB use of deadly force did not fall within the criteria for automatic review by the District Attorney's Office. The District Attorney did an initial assessment of the facts (which overlapped with the criminal investigation and filing of charges against Connelly) and determined that no further evaluation of the officers' actions was needed.

In July of 2023, Mr. Connelly pled guilty to a number of charges relating to the incident and was sentenced to several years in prison.

The Bureau's policy assessment covered three areas: the three officers' respective use of deadly force, the operational planning and management of the incident itself, and compliance with post-incident investigative protocols at the scene. All phases of the review process resulted in findings that personnel acted within policy.

The Training Division's analysis, which contributed to the ultimate findings, assessed several aspects of the incident separately. In each instance, the analysis determined that the relevant officers' actions "fell within an accepted range." This included the initial planning and staging of the operation to arrest Mr. Connelly, the attempt to contact and arrest him that instigated the foot pursuit, the pursuit itself, the officer-involved shooting, the subsequent tactical operation that resulted in Mr. Connelly's surrender, and the actions of supervisors who managed the incident and its immediate aftermath.

OIR Group Review and Analysis

We found the Training Division's report to be particularly methodical and thoughtful here. It was interesting to note that there were arguably shortcomings at several key points at the initial moments of the incident. But the Training analysis was persuasive in putting these issues into context and delineating the factors that accounted for them.

For example, the operations plan itself appeared to be appropriately comprehensive in identifying risks and preparing for contingencies. To us, Mr. Connelly's attempt to run was a highly predictable response to the outdoor arrest strategy, but it was a choice that was made consciously and with the sense that it would be safer. And though the deployment of a nearby K-9 would seemingly have been useful, the Training report noted that the K-9 officer affirmatively declined to release his dog due to the presence of the other pursuing officers in close proximity.

The foot pursuit itself was relatively short and consistent with Bureau guidelines on safety considerations. Even so, the Training analysis noted (with acknowledgement of the benefits of hindsight) that a brief pause for assessment when the subject entered the parking lot would have been beneficial as an opportunity to consider cover and other tactical advantages.

The suddenness with which Mr. Connelly changed direction and found himself within feet of Sergeant Elam and Officer Baten, facing them and then pointing his gun at them in turn, obviously influenced the imperfections in their efforts to defend themselves and/or each other by shooting. Officer Li, for example, quickly took cover behind a car but then fired several rounds directly into its windshield; Officer Baten was found to have lacked “fully aimed” fire at times. While acknowledging these concerns, the analysis also cited their predictability in the context of the evolving situation. It also credited the officers for the things they appeared to do well, which included making quick adjustments, continuing to assess, and ensuring a safe, appropriate backdrop in their direction of fire. (No accidental injuries resulted from the shooting.) Certainly, their perception of a deadly threat justifying their own force was well-supported by the evidence.

The Training review did produce two recommendations. The first was that the Bureau prioritize its burgeoning commitment to a “Red Dot Sight” equipment addition to officer firearms. The report cited this as a means of enhancing target acquisition and accuracy in circumstances such as this, in which split-second adjustments became necessary for officers who were on the move. It was a response to the reality that the three officers fired a total of 27 rounds without striking the subject, and (as the scene evidence established) without establishing tight groupings.

The Training Division’s recommendations were particularly apt here. The specific equipment enhancement (red dot sights) espoused in the report would presumably have made a difference in this encounter, for the reasons persuasively articulated here. The Bureau has since begun issuing all new officers weapons equipped with red dot sights and continues to transition tenured officers to this equipment upgrade.

The Training Division Review also recommended that the incident be shared as training resource regarding the dangers of foot pursuits. The Division’s own analysis would be an excellent foundation for this suggestion.

Common Themes and Issues

Portland's Review Process: Consistency and Follow-Through

The administrative review process following a PPB officer-involved shooting has many layers: Internal Affairs investigates and makes recommended findings, which are forwarded to the Reporting Unit Manager (a Commander) for review and proposed findings. From there the case and proposed findings are sent to the Independent Police Review and the Chief's office for review before the case is set for a Police Review Board meeting. At the same time, the Training Division reviews the investigation, draws conclusions about whether the officers' actions were consistent with their training and often makes its own set of recommendations around training or equipment issues. The PRB reviews all of this material and makes recommendations and findings, which are then sent to the Chief and the Police Commissioner for final disposition.

In the 10 cases we evaluate in this report, we noted disparity in the approaches to corralling the various recommendations made by different reviewers. In some cases, the Chief's Office assessed each recommendation and decided whether to adopt, reject, or modify the recommendation. This was documented in a memo, along with the reasoning for each decision, a plan for implementation, assignment to a particular unit, and a timeline for reporting back – all steps that contribute to effective follow-through and that we endorse. But this was hardly a consistent practice.

Additionally, as we detailed in each of our case descriptions, these incidents led to a number of helpful recommendations from Training. In fact, as we have often noted in prior reports, the written Training Division Reviews are generally exemplary. Few other agencies prepare such comprehensive documentation or candid, insightful analyses of their

officer-involved shootings and other critical incidents. But – and to reiterate, as we have repeatedly mentioned in past reports – the lack of a formal mechanism for considering, adopting, and implementing these recommendations results in lost opportunities for the Bureau to learn and improve from these incidents.

In our conversations with the Bureau, we learned that it had been using a data system to track all recommendations associated with a given officer-involved shooting, but it lost access to this database. At our request, the Bureau provided information regarding the status of the recommendations made in each of these 10 shootings. This was helpful for our analysis and reporting, and substantive information about progress was often encouraging. But it is not a substitute for the type of formal consideration and documentation of recommendations we have advocated for in a number of prior reports.

An ideal critical incident review process ensures a holistic, thorough, timely review – elements the PPB process generally does well – but also includes both formal recommendations or action items and a feedback loop to ensure that the recommended actions are completed. This latter component continues to be lacking. We recommend the Bureau adopt a more structured process at the conclusion of each critical incident investigation and review that brings together the various elements of the process and effectively addresses each issue raised.

While the details are best determined by the Bureau, our vision would include a meeting of executives, Professional Standards, and Training personnel in which participants most familiar with the incident discuss all findings and recommendations made by Training, the Reporting Unit Manager, and the Police Review Board. The group should establish a clear list of “action items” with assignments given to participants for appropriate follow-up relating to systemic issues and to discuss any additional actions needed. The process should include an effective mechanism for documenting the outcome of the meeting and providing feedback to the group, to ensure thorough and timely completion of assigned action items.

RECOMMENDATION 6: The Bureau should develop a structured process for considering, adopting, and implementing recommended reforms that emerge from the reviews of each shooting incident, with an emphasis on documentation and specific "action items" to facilitate timely and effective follow through.

Communication and Coordination Among Officers

In several of the cases we reviewed, the overall response could have been improved if responding officers had communicated more effectively and developed a more coherent plan for coordinated actions. In some cases – exemplified in the incident involving Mr. Henriksen – officers acknowledged the need for additional coordination but were compelled by exigency of the public safety threat to leave their staging location before fully developing their plan. In others – those involving Mr. Dahlen and Mr. Carr, for example – officers did not make use of available time to communicate with each other about plans and contingencies. In the Dahlen matter, the lack of planning resulted in confusion regarding whether a box-in of the vehicle was being performed. In Carr, better direct verbal communication between officers would have been beneficial to the officers' ability to execute their plan while adapting to changing circumstances.

The Training Division Reviews in these cases addressed these communications issues in various ways but did not include any plans for formal remediation or other training plans – either for the individual officers or on a Bureau-wide basis. Communication and coordination between partners to plan, assign responsibilities, and discuss possible contingencies is a fundamental part of officer training for tactical scenarios. When the Bureau (through its Training Division Reviews) identifies deficiencies in this important discipline, particularly in deadly force events, it is crucial that this issue is debriefed with all involved officers so the incident can be used as an effective learning tool.

OIR Group Reviews Delayed Pending Resolution of Litigation

Two officer-involved shootings were closed and would have been included in this report, but our review of those two incidents was held up because there remains ongoing litigation related to both. This issue was seemingly resolved after our first report regarding the PPB, following the in-custody death of James Chasse. In that case, many review mechanisms were unfortunately delayed for years as a result of pending litigation.

The City Auditor at that time determined that future reviews of officer-involved shootings and in-custody deaths would not be contingent upon completion of all pending litigation. In the Auditor's transmittal memorandum to Council that accompanied our Chasse report, she explained:

We also did not delay the expert review pending civil litigation because we have been convinced that to be meaningful and relevant to City officials, the Police Bureau, and the public, such reviews should be timely, occurring as close to the event and investigations as possible. The primary purpose of these reviews is to determine what improvements should be made in existing police practices and tactical decision-making, as well as in the mechanisms used for police oversight. Waiting until civil litigation ends before conducting expert reviews undermines that goal, largely because civil lawsuits in these matters tend to go on for many years. Further, OIR Group's report recommends that outside reviews of critical incidents should not be dictated by the pace of any resulting litigation. We concur, and in the future, we plan to launch expert reviews of all such cases at the close of investigations, contingent upon the availability of financial resources.

We supported that approach in our report and made it a formal recommendation:

The City has a long and admirable tradition of seeking outside review of critical incidents. Members of the Bureau with whom we spoke expressed widespread appreciation for the value of independent review of these incidents. However, the practice

has traditionally included long delays waiting for the conclusion of civil litigation before initiating outside review. In our view, this has greatly diminished its potential benefits. We support the City Auditor's decision to initiate the review of the Chasse incident prior to the conclusion of the litigation, and hope she continues that practice going forward.

Recommendation: Outside review of critical incidents should not be dictated by the pace of any resulting litigation.

We have received no explanation for the sea change in approach here and believe that the rationale for not delaying reviews due to pending litigation holds. We request that the City reconsider this change and reiterate our 2010 recommendation:

RECOMMENDATION 7: Outside review of critical incidents should not be dictated by the pace of any resulting litigation.

Recommendations

- 1: The Bureau should modify its deliberative protocols so that the review of every officer-involved shooting includes an explicit review of pre-shooting tactical decision making, and express findings from the Commander and Police Review Board on whether officers' tactical performance was consistent with training and policy.
- 2: The Training Division should evaluate the efficacy of using a parked vehicle as part of a box-in technique and update its training curriculum accordingly.
- 3: Where photographic or forensic evidence conflicts with an officer's account of the incident, the Bureau's investigation should examine and ask the officer to explain any potential discrepancy.
- 4: The Bureau should work with BOEC leaders to develop a training bulletin for dispatchers on recognizing and conveying to officers relevant information about the possibility of a subject seeking self-harm through police intervention.
- 5: The Bureau should modify its directives and training to require that an officer seek and obtain approval from a supervisor before engaging in a PIT maneuver.
- 6: The Bureau should develop a structured process for considering, adopting, and implementing recommended reforms that emerge from the reviews of each shooting incident, with an emphasis on documentation and specific "action items" to facilitate timely and effective follow through.
- 7: Outside review of critical incidents should not be dictated by the pace of any resulting litigation.

Table of Critical Incidents Reviewed by OIR Group

2004 – 2022

Subject's name	Date	# of shooting officers	# of rounds fired	Officers' weapon	Hit/non-hit	Fatal/non-fatal	Subject weapon?	Subject's Race/Ethnicity	Mental health issues	Officer(s) disciplined?
James Jahar Perez	3/28/04	1	3	9mm	Hit	Fatal	Unarmed	African-American	No	No
Marcello Vaida	10/12/05	2	38	9mm	Hit	Non-fatal	Handgun	African-American	No	No
Raymond Gwerder	11/4/05	1	1	AR-15	Hit	Fatal	Handgun	White	Yes	No
Dennis Lamar Young	1/3/06	1	2	9mm	Hit	Fatal	None (subject drove vehicle at shooting officer)	White	No	Yes ^a
Timothy Grant	3/20/06	1	N/A	N/A	N/A	In-custody death	N/A	White	No	No
Jerry Goins	7/19/06	1	4	9mm	Hit	Fatal ^b	Handgun	White	Yes	No

Subject's name	Date	# of shooting officers	# of rounds fired	Officers' weapon	Hit/non-hit	Fatal/non-fatal	Subject weapon?	Subject's Race/Ethnicity	Mental health issues	Officer(s) disciplined?
Scott Suran	8/28/06	1	2	AR-15	Hit	Non-fatal	None	White	No	No
James Chasse	9/17/06	3	N/A	N/A	N/A	In-custody death	N/A	White	Yes	No
David Earl Hughes	11/12/06	3	15	9mm (2); AR-15 (1)	Hit	Fatal	None	White	Yes	No
Dupree Carter	12/28/06	1	2	9mm	Non-hit	Non-fatal	Handgun	African-American	No	No
Steven Bolen	5/22/07	2	10	9mm; AR-15	Hit	Fatal	Shotgun	White	No	No
Leslie Stewart	8/20/07	1	1	AR-15	Hit	Non-fatal	None	African-American	No	No
Jeffrey Turpin	10/5/07	1	4	9mm	Hit	Fatal	Handgun	White	Yes	No
Jason Spoor	5/13/08	2	2	9mm	Hit	Fatal	Handgun	African-American	Yes	No
Derek Coady	5/15/08	1	2	9m	Non-hit	Fatal ^d	Handgun	White	Yes	No

Subject's name	Date	# of shooting officers	# of rounds fired	Officers' weapon	Hit/ non-hit	Fatal/ non-fatal	Subject weapon?	Subject's Race/ Ethnicity	Mental health issues	Officer(s) disciplined?
Osmar Lovaina-Bermudez	8/24/09	1	3	AR-15	Hit	Non-fatal	Handgun	Hispanic	No	No
Aaron Campbell	1/29/10	1	1	AR-15	Hit	Fatal	None	African-American	Yes	Yes ^e
Jack Dale Collins	3/22/10	1	4	9mm	Hit	Fatal	Knife	White	Yes	No
Keaton Otis	5/12/10	2	19-21	9mm	Hit	Fatal	Handgun	African-American	Yes	No
Craig Boehler	11/23/10	1	3	AR-15	Hit	Fatal ^f	Handgun and rifle	White	No	No
Darryll Ferguson	12/17/10	2	20	9mm	Hit	Fatal	Replica handgun/ BB gun	White	No	No
Marcus Lagozzino	12/27/10	1	4	AR-15	Hit	Non-fatal	Machete	White	Yes	No
Kevin Moffett	1/1/11	1	1	9mm	Non-hit	Non-fatal	Handgun	African-American	No	No

Subject's name	Date	# of shooting officers	# of rounds fired	Officers' weapon	Hit/non-hit	Fatal/non-fatal	Subject weapon?	Subject's Race/Ethnicity	Mental health issues	Officer(s) disciplined?
Thomas Higginbotham	1/2/11	2	12	9mm	Hit	Fatal	Knife	White	Yes	No
Ralph Turner	3/6/11	2	4-5; then cover fire	9mm; AR-15	Non-hit	Non-fatal	Rifle, shotgun, and handgun	White	Yes	No
William Kyle Monroe	6/30/11	1	4	Less-lethal shotgun loaded with lethal rounds	Hit	Non-fatal	None	White	Yes	Yes
Darris Johnson	7/9/11	3	N/A	N/A	N/A	In-custody death	N/A	African-American	No	No
Brad Lee Morgan	1/25/12	2	5	9mm	Hit	Fatal	Replica handgun	White	Yes	No

Subject's name	Date	# of shooting officers	# of rounds fired	Officers' weapon	Hit/ non-hit	Fatal/ non-fatal	Subject weapon?	Subject's Race/ Ethnicity	Mental health issues	Officer(s) disciplined?
Jonah Aaron Potter	3/26/12	4	7	9mm (2); M4 (1); M16 (1)	Hit	Non-fatal	Replica handgun/ BB gun	White	Yes	No
Juwan Blackmon	7/17/12	1	1	9mm	Hit	Non-fatal	Handgun	African-American	No	No
Billy Wayne Simms	7/28/12	1	6	AR-15	Hit	Fatal	Handgun (unloaded)	White	No	No
Michael Tate	8/21/12	1	2	9mm	Non-hit	Non-fatal	None (subject raised hand holding cell phone)	Hispanic	Yes	No
Joshua Baker	9/29/12	2	17	9mm; AR-15	Hit	Non-fatal	Rifle	White	Yes	No

Subject's name	Date	# of shooting officers	# of rounds fired	Officers' weapon	Hit/non-hit	Fatal/non-fatal	Subject weapon?	Subject's Race/Ethnicity	Mental health issues	Officer(s) disciplined?
Merle Hatch	2/17/13	3	19	9mm (2) AR-15 (1)	Hit	Fatal	None (subject pretended telephone receiver was a handgun)	White	Yes	No
Santiago Cisneros	3/4/13	2	22	9mm	Hit	Fatal	Shotgun	Hispanic	Yes	No
Kelly Swoboda	3/12/14	1	4	9mm	Hit	Fatal	Handgun	White	No	No
Paul Ropp	4/16/14	2	15	9mm	Hit	Non-fatal	Rifle	White	No	No
Nicholas Davis	6/12/14	1	2	9mm	Hit	Fatal	Crowbar	White	Yes	No
Denoris McClendon	9/1/14	1	2	Shotgun	Hit	Non-fatal	Replica handgun/ BB gun	African-American	Yes	No

Subject's name	Date	# of shooting officers	# of rounds fired	Officers' weapon	Hit/ non-hit	Fatal/ non-fatal	Subject weapon?	Subject's Race/ Ethnicity	Mental health issues	Officer(s) disciplined?
Ryan Sudlow	2/17/15	1	1	9mm	Non-hit	Non-fatal	None	White	No	No
Christopher Healy	3/22/15	1	2	9mm	Hit	Fatal	Knife	White	Yes	No
Michael Harrison	5/17/15	1	7	9mm	Hit	Non-fatal	Knife	White	Yes	No
Alan Bellew	6/28/15	2	14	9mm	Hit	Fatal	Replica handgun/ starter pistol	White	No	No
David Ellis	7/5/15	1	1	9mm	Hit	Non-fatal	Knife	White	Yes	No
Michael Johnson	11/6/15	2	7	M4 rifle	Hit	Fatal	Handgun	White	Yes	No
Timothy Bucher	5/24/16	2	16	M4 rifle; .223 rifle	Non-hit	Non-fatal	Assault rifle and handgun	White	Yes	No

Subject's name	Date	# of shooting officers	# of rounds fired	Officers' weapon	Hit/non-hit	Fatal/non-fatal	Subject weapon?	Subject's Race/Ethnicity	Mental health issues	Officer(s) disciplined?
Steven Liffel	12/5/16	1	1	AR-15	Hit	Fatal	Rifle and handgun	White	Yes	No
Quanice Hayes	2/9/17	1	3	AR-15	Hit	Fatal	Replica handgun	African-American	No	No
Don Perkins	2/9/17	2	10	AR-15; 9mm	Hit	Non-fatal	Replica handgun	White	Yes	No
Terrell Johnson	5/10/17	1	4	9mm	Hit	Fatal	Knife	African-American	No	No
Michael Grubbe	5/28/17	3	15	Shotgun (2) 9mm (1)	Non-hit	Non-fatal	Replica handgun/ BB gun	White	Yes	No
Jesse Brockner	8/30/17	1	3	9mm	Hit	Non-fatal	Handgun	White	No	No
Chase Peeples	10/27/17	1	6	9mm	Hit	Non-fatal	None	African-American	Yes	No
Sarah Brown	3/8/18	2	30	9mm; AR-15	Hit	Non-fatal	Handgun	White	Yes	No

Subject's name	Date	# of shooting officers	# of rounds fired	Officers' weapon	Hit/non-hit	Fatal/non-fatal	Subject weapon?	Subject's Race/Ethnicity	Mental health issues	Officer(s) disciplined?
John Elifritz	4/7/18	5 PPB officers 1 MCSO deputy	17	AR-15 (3) handgun (2) shotgun (1)	Hit	Fatal	Knife	White	Yes	No
Jonathan Harris	8/31/18	1	N/A	N/A	N/A	Non-fatal use of deadly force	Handgun	African-American	No	No
Patrick Kimmons	9/30/18	2	16	9mm	Hit	Fatal	Handgun	African-American	No	No
Samuel Rice	10/10/18	1	1	AR-15	Hit	Fatal	Knife	White	Yes	No
Jason Hansen	10/19/18	1	3	9mm	Hit	Non-fatal	Handgun	White	No	No
Richard Barry	11/22/18	2	N/A	N/A	N/A	In-custody death	N/A	White	Yes	No

Subject's name	Date	# of shooting officers	# of rounds fired	Officers' weapon	Hit/ non-hit	Fatal/ non-fatal	Subject weapon?	Subject's Race/ Ethnicity	Mental health issues	Officer(s) disciplined?
Ryan Beisley	12/7/18	4	18	9mm; shotgun	Hit	Non-fatal	Replica handgun/ BB gun	White	Yes	No
Andre Gladen	1/6/19	1	3	9mm	Hit	Fatal	Knife	African-American	Yes	No
Jeb Brock	4/26/19	2	2	9mm	Hit	Fatal	Knife	White	Yes	No
David Downs	6/9/19	1	1	9mm	Hit	Fatal	Knife	White	No	No
Anita Ruiz	1/2/19	1	1	9mm	Non-hit	N/A	Knife	Hispanic	Unknown	No
Lane Martin	7/30/19	1	11	9mm	Hit	Fatal	Knife	White	Yes	No
Kobin Henriksen	12/8/19	1	3	AR-15	Hit	Fatal	Two knives	White	Yes	No
Grey Stockton	6/28/20	1	3	9mm	Non-hit	N/A	Replica handgun / pellet gun	White	Yes	No
David Dahlen	12/24/20	1	2	9mm	Non-hit	N/A	Vehicle	White	No	No

Subject's name	Date	# of shooting officers	# of rounds fired	Officers' weapon	Hit/non-hit	Fatal/non-fatal	Subject weapon?	Subject's Race/Ethnicity	Mental health issues	Officer(s) disciplined?
Tai Tran	3/30/21	0	N/A	N/A	N/A	Fatal ⁹	Handgun	Asian	Yes	No
Darrin Carr	5/22/21	1	8	9mm	Non-hit	N/A	Vehicle	White	No	No
Joshua Merritt	7/20/21	1	1	9mm	Hit	Non-fatal	Broken bottle	White	Yes	No
Brandon Keck	12/6/21	1	10	AR-15	Hit	Fatal	Handgun; vehicle	White	Unknown	No
Joshua Degerness	12/11/21	2	16	9mm	Hit	Non-fatal	Handgun	White	Unknown	No for involved officer but Supervisor found out of policy
Robert Connelly	8/16/22	3	30	9mm	Non-hit	N/A	Handgun	White	No	No

-----Reviewed in OIR Group’s Report Concerning the In-Custody Death of James Chasse, July 2010

-----Reviewed in OIR Group’s Report on Portland Police Bureau Officer-Involved Shootings, First Report, May 2012

-----Reviewed in OIR Group’s Report on Portland Police Bureau Officer-Involved Shootings, Second Report, July 2013

-----Reviewed in OIR Group’s Report on Portland Police Bureau Officer-Involved Shootings, Third Report, November 2014

(no shading) Reviewed in OIR Group’s Report on Portland Police Bureau Officer-Involved Shootings, Fourth Report, January 2016

-----Reviewed in OIR Group’s Report on Portland Police Bureau Officer-Involved Shootings, Fifth Report, February 2018

-----Reviewed in OIR Group’s Report on Portland Police Bureau Officer-Involved Shootings, Sixth Report, January 2019

-----Reviewed in OIR Group’s Report on Portland Police Bureau Officer-Involved Shootings, Seventh Report, April 2020

-----Reviewed in OIR Group’s Report on Portland Police Bureau Officer-Involved Shootings, Eighth Report, November 2022

-----Reviewed in OIR Group’s Report on Portland Police Bureau Officer-Involved Shootings, Ninth Report, January 2026

^aThe Bureau made the decision to terminate the shooting officer. The decision was overturned by the Arbitrator, and he was instead suspended for 30 days.

^bAfter being struck by the officer’s gunfire, Mr. Goins raised his gun to his own head and shot himself. The Medical Examiner ruled the cause of death to be suicide.

^dAfter both of the officers’ shots missed, Mr. Coady shot himself in the head. The Medical Examiner ruled the cause of death to be suicide.

^eThe Bureau made the decision to terminate the shooting officer. The decision was overturned by the Arbitrator, and that decision was confirmed on appeal.

^fNone of three rounds fired were deemed fatal, but Mr. Boehler died of smoke inhalation in the ensuing fire in his house.

^g During the course of the standoff with officers, Mr. Tran shot himself in the head. The Medical Examiner ruled the cause of death to be suicide. No officers fired their weapons.



CITY OF PORTLAND, OREGON



Bureau of Police

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Integrity • Compassion • Accountability • Respect • Excellence • Service

January 5, 2026

Director Ross Caldwell
Independent Police Review
1221 SW 4th Avenue, Room 140
Portland, OR 97204

Dear Director Caldwell:

I appreciate the opportunity to review and respond to the ninth report and recommendations from the OIR Group regarding Portland Police Bureau officer-involved shootings from January 2019 – August 2022.

Every time a Portland Police Officer uses deadly force in the course of their employment, it has significant and widespread impacts. The events don't just affect the person upon whom deadly force was used, but also their friends and family, witnesses, Police Bureau members, and the community at large. Due the thoughtful analysis of the OIR Group over the course of many reports, we have been able to continually improve our investigations of these events. This has enabled us to identify training and policy needs, thus improving future outcomes. In addition to their thoughtful recommendations, we also appreciate the OIR Group's recognition of our hard work.

Please see the individual comments on each recommendation below. We appreciate and enjoy the collaborative relationship we have with the OIR Group. Their insights and comments have been very influential, and their feedback and recommendations have been instrumental in our continued progress.

Sincerely,

ROBERT DAY
Chief of Police

RD/jmb

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Portland Police Bureau Responses to OIR Group Ninth Report to the City of Portland Portland Police Bureau Officer-Involved Shootings

- 1. The Bureau should modify its deliberative protocols so that the review of every officer-involved shooting includes an explicit review of pre-shooting tactical decision making, and express findings from the Commander and Police Review Board on whether officers' tactical performance was consistent with training and policy.**

Agree. Partially in practice.

Internal Affairs has been using a specific area of review called “Operational Planning and Supervision” to evaluate the actions of supervisors prior to the use of deadly force. Internal Affairs will develop another area of review to also explicitly look at the pre-shooting actions of individual officers. Under our current policies, this type of review will be evaluated under directive 315.30 – Satisfactory Performance, section 2: “This subsection sets performance standards for decision-making during confrontations and requires that members use sound tactics and good decision-making during a confrontation.”

- 2. The Training Division should evaluate the efficacy of using a parked vehicle as part of a box-in technique and update its training curriculum accordingly.**

Agree. In practice.

The current policy does not have a provision for using a box-in on a parked vehicle. Since the date of this incident directive 630.05 – Vehicle Interventions and Pursuits has been changed to allow boxing in a vehicle using a “fixed object”. This did not include using a parked car as they are not considered fixed objects.

Training has been teaching Advanced Academy students in the box-in of stationary vehicles utilizing a fixed object since early January 2024. Since people do not typically park or stop against fixed objects, this requires officers to push the vehicle to the fixed object to close the distance and make this tactic effective. This training will be provided to all sworn members during the 2026 in-service.

The pending policy release of 630.05, allows utilizing a box-in against a parked vehicle when it is reasonably believed to be unoccupied. The idea is that this technique will likely be used where an opportunity that arises where the parked car may take the place of a second police car when it is not feasible to use two police cars. The policy will dictate that the benefit of this type of box-in must outweigh the risks. When the 630.05 update is released, this technique will be taught in the same manner as fixed objects box-ins.

- 3. Where photographic or forensic evidence conflicts with an officer's account of the incident, the Bureau's investigation should examine and ask the officer to explain any potential discrepancy.**

Agree. In practice.

Internal Affairs moved to include a “discrepancies” section in all administrative investigation reports several years ago. This section directly addresses issues where there are inconsistencies in

member/witness statements and/or physical evidence. Internal Affairs will ensure that they keep using this practice for subsequent reports.

4. The PPB should work with BOEC leaders to develop a training bulletin for dispatchers on recognizing and conveying to officers relevant information about the possibility of a subject seeking self-harm through police intervention.

Agree. In practice.

The Training Division has confirmed with BOEC that all new hires receive relevant training at their Basic Academy in a course titled “Suicidal Callers”. This course has a specific component about “suicide by cop” events.

5. The Bureau should modify its directives and training to require that an officer seek and obtain approval from a supervisor before engaging in a PIT maneuver.

Disagree in part.

A PIT is rightly considered a use of force, and as such, it is subject to the same requirements and review process as any other use of force. If the Bureau were to require an officer to seek approval prior to a PIT, it would be the only use of force which would require that officers gain approval prior to deployment. While we recognize that a PIT maneuver is different than other uses of force, we don’t want to restrict our officers’ ability to end a pursuit by requiring permission prior to its use.

Prior versions of directive 630.05 encouraged officers to notify a supervisor prior to performing a PIT, but it was never required. However, training curricula has always focused on the need to communicate and plan ahead for PITs whenever possible to increase the safety of the maneuver and the chance of success. We will have our policy team look at reintroducing this concept back into the policy to help reinforce the importance of communication and coordination when performing a PIT.

6. The Bureau should develop a structured process for considering, adopting, and implementing recommended reforms that emerge from the reviews of each shooting incident, with an emphasis on documentation and specific "action items" to facilitate timely and effective follow through.

Agree. Partially In Practice.

The Police Bureau has been tracking recommendations from a variety of sources for years in several different forms. The tracking mechanism has used several different software programs and has been administered by both the Chief’s Office and the Professional Standards Division (PSD). PSD is currently testing a new system which will automate workflows and make it easier to track, and thus ensure the accountability of, the decision-making and assignment of these recommendations. The goal is to have the structure detailed in a directive in the near future.

7. Outside review of critical incidents should not be dictated by the pace of any resulting litigation.

Agree.

The Bureau recognizes the advantages of reviewing these critical incidents quickly in order to timely address identified gaps in policy or training. However, the public dissemination of this type of analysis while cases remain in pending litigation or subject to future claims can complicate litigation, particularly if there are inaccuracies in the description of the events that occurred. The Police Bureau requests that a draft of such cases in litigation be reviewed by the City Attorney's Office prior to finalizing the report to allow for discussion and confirmation of the accuracy of factual summaries.