#1

Dear CCOC Subcommittee members,

I'm writing with some suggestion regarding your draft recommendations. A number of them express very worthwhile ideas (a valid starting point to work from), but require modification to have utility.

I believe it's essential that you extend your current deadline, to give yourselves more time to craft useful recommendations.

1. Some recommendations are attempting to address problems that genuinely need to be addressed, but as currently written are too vague to have utility (to bring about the desired outcomes).

That's true with some of the subrecommendations in "Addressing mental health and substance abuse issues"

11 of the last 12 MPD officer involved shootings have been of people incapacitated by mental illness and/or chemically. It is indeed a very serious problem that needs to be addressed.

Recommendation 1 sounds superficially fine: "Recommendation 1: Increase the level of training for officers to interact with people experiencing a mental health crisis or intoxication."

But what does this recommendation actually mean? What does it actually do? Will it actually improve the problem?

Note that the rate of MPD officer involved shootings of people who are mentally ill or chemically incapacitated has been increasing over the same period of time that MPD has been increasing/expanding Crisis Intervention Training (now required of all incoming recruits). Simply increasing the level of such training is not working.

The officer who engaged in excessive use of force in the Genele Laird case was actually an MPD Mental Health Liaison Officer – he'd received the highest level of Crisis Intervention Training.

Randomized controlled trials of Crisis Intervention Training have, so far, basically failed to show a reduction in use of force as a result of the training.

You need a recommendation that addresses the variables that matter for effective training – the type of training, the frequency, whether all officers receive training, etc. You need to find language that will actually make a difference.

I've been advocating incorporation of ProTraining (the Edmonton Model), since: 1. There's some evidence base for its efficacy in reducing use of force with people with mental health issues, 2. Unlike much standard crisis intervention training, it's specifically designed to change officer behavior (to reduce use of force and improve the quality of interactions). 3. It's time

efficient – only requiring a very limited number of hours (so can be added on to conventional crisis intervention training). 4. It provides a generalized practical skill set for handling people in crisis, rather than emphasizing intellectual knowledge of mental illness.

I've documented ProTraining more in prior e-mails.

If you want more general language, rather than referring to ProTraining per se, you perhaps could ask for training that's evidence-based and specifically designed to modify officer behavior to reduce use of force on people with mental health issues.

The frequency of training is also key. In general crisis intervention training is given once. But the science shows that refresher training is critical. Some police departments are now having all officers do repeat crisis intervention training every three years. And ProTraining is designed to have a refresher every three years.

The last recommendation in the set under "Addressing mental health and substance abuse issues" is also very vague: "Recommendation 3: Establish policies for mental health teams."

What's really needed, to reduce the disastrous use of force outcomes that have been occurring, is policy specifically addressing handling of resistant people with mental health and substance abuse issues. MPD has policy for dealing with mentally ill subjects (e.g. to help guide officers in assessing whether someone needs treatment). But specific policy to prevent tragic use of force outcomes with resistant mentally ill subjects is completely lacking. It's crucial that policy gap be rectified.

Some language from an early policy draft Chris Taylor's office was working on a few months ago:

"Emotional Disturbances: Treat the arrest of a subject exhibiting symptoms of a drug-induced psychosis or a psychotic episode as a medical emergency.[1] Adopt NYPD approach to these situations.[2]
1. Based on Dallas PD language: http://static1.squarespace.com/static/56996151cbced68b170389f4/t/569ad58a0e4c1148e6b1079b/1452987794280/Dallas+Use+of+Force+Policy.pdf
2. http://www.nyc.gov/html/ccrb/downloads/pdf/2016pg/pg221-13-mentally-ill-emotionally-disturbed-persons.pdf "

Here's some alternative draft language for "**Addressing mental health and substance abuse issues**"

> **Issue: The vast majority of officer-involved shootings in the last decade in the City of Madison have involved a person with a mental health issue or intoxication.**

Recommendation 1: Increase the level of training for officers to interact with people experiencing a mental health crisis or intoxication. Specifically:

a. Increase training with mental health training systems that are evidence based and designed to alter behavior of officers to reduce use of force and improve the quality of interactions. [alternative language for this point: Incorporate use of the ProTraining mental health training system, given its evidence of efficacy in improving outcomes.]

b. Provide mental health training to all officers.

c. Provide periodic refresher training to all officers.

Recommendation 2: Hire social workers who have expertise in mental health and substance abuse issues to work with officers in every district on every shift.

Recommendation 3: Develop specific policy for responding to, and averting adverse outcomes with, resistant subjects with mental health or substance abuse issues. Adopt James Fyfe's Principles and NYPD's approach for such situations. Treat the arrest of a subject exhibiting symyoms of a drug-induced psychosis or a psychotic episode as a medical emergency.

2. The "Use of Force" recommendations also need modification. It's not correct that MPD currently has none of these provisions in its policy. Moreover, the current draft language is too vague. Furthermore, the "backup" provision (currently recommendation 2 in this set) would be unrealistic in practice. 7 feet doesn't account for needed reaction time. There's a valid idea that officers should wait for backup before engaging. There's a valid idea that the threshold for use of deadly force should be "immediate threat" rather than the less restrictive "imminent threat" (which MPD currently uses). Though it's internally inconsistent, since both terms are used in the recommendation. It's not viable as written.

Here's alternative language for this section. I've removed language about waiting for backup – it can be addressed elsewhere.

Use of Force Policies

"Issue: The Madison Police Department Use of Force Policies do not include precautionary principles which reduce the likelihood of adverse outcomes and which are contained in similar policies from other police departments.

Recommendation: The Council will direct the Chief of Police to incorporate the following precautionary principles, as identified by Rep. Chris Taylor, into the MPD Use of Force and Use of Deadly Force policies:

1. Duty to Preserve Life: The primary duty of all members of the service is to preserve human life, including the lives of individuals being placed in police custody.

2. Necessity: Deadly force should only be used as a last resort. The necessity to use deadly force arises when all other available means of preventing immediate and grave danger to officers or other persons have failed or would be likely to fail.

3. Proportionality: It is this department's policy to accomplish the police mission with the cooperation of the public, with minimum reliance upon the use of physical force. When force is needed, the force used shall be in proportion to the threat posed.

4. Reassessment: Officers shall reassess the situation after each discharge of their firearm.

5. Totality of officer conduct: The reasonableness of an officer's use of force includes consideration of the officer's tactical conduct and decisions leading up to the use of force. Police officers shall ensure their actions do not precipitate the use of deadly force by placing themselves or others in jeopardy by taking unnecessary, overly aggressive, or improper actions. It is often a tactically superior police procedure to withdraw, take cover or reposition, rather than the immediate use of force.

6. Immediate threat: Deadly force is only authorized if the threat is immediate. A threshold of "immediate threat" reflects language in United States Supreme Court decisions. The latest model use of force policy published by the International Association of Chiefs of Police eliminates the term "imminent".

In addition, the following precautionary principles, which are addressed elsewhere in MPD policy, should be explicitly referenced in the MPD Use of Force and Use of Deadly Force Policies.

7. De-escalation: De-escalation tactics and techniques are actions used by officers which seek to minimize the likelihood of the need to use force during an incident. Officers shall attempt to slow down or stabilize the situation so that more time, options and resources are available for incident resolution.

8. Duty to Intercede: Officers have a duty to intercede to stop other officers who are using excessive force and report them to a supervisor.

3. "Safety in Numbers" states "MPD policy should state that two officers should be working together if at all possible." Though the motive behind this is good (and indeed I think it's important to wait for backup before approaching situations), mandating that everything (patrol, etc.) be done in pairs would decrease coverage and exponentially increase political pressure to hire many more officers (at the expense of other essential city services). Moreover, former Chief David Couper strongly sees such a practice as bad policy because if cops are always in pairs, they'll be talking to each other rather than to residents. One illustration of this problem can be seen in what's happening with MPD's "Community Policing Teams" – MPD converted

most Neighborhood Officer positions into Community Policing Team positions, to the great detriment of its community policing efforts.

I am strongly opposed to this policy recommendation. However, the valid idea behind it is worth noting. Richmond CA greatly decreased its rate of officer involved shootings, and that department believes one key to this was a shift in training in policy to emphasize the need to wait for backups before engaging. MPD now has a policy provision that specifies that officers should wait for backup before engaging.

MPD implemented a policy requiring that officers wait for backup, but then subsequently weakened the policy (i.e. under the newest policy, you can't just disregard backup, but there's no longer language really requiring officers to wait for backup before physically approaching). On Nov 16 the key passage in dispatch policy was changed from this:
"Officers shall not disregard backup, if so assigned by dispatch. Additionally, officers shall wait for backup before physically approaching any involved subject(s), unless an officer reasonably believes there is a significant risk of bodily injury to any person(s)."
to this:
"Officers shall not disregard backup, if so assigned by dispatch, prior to arrival at the scene and assessment of the situation."

Simply verbally acknowledging the backup officer over radio (prior to arrival at the scene), then proceeding to physically approach the subject alone, would appear to satisfy the newest policy. For the "Safety in Numbers" section, you may wish to recommend that MPD revert to its original (more restrictive) backup policy. Of course, some people may complain – why is a responding officer just standing around and not doing anything. But the benefit, in reducing adverse outcomes, may be substantial.

Potential alternative language for the "**Safety in Numbers**" section:

> **Issue: Officers are at higher risk, and may be more likely to use deadly force because of that risk, when they engage alone in a situation in which there may potentially be a resistant subject.**
>
> **Recommendation: Training and policy should strongly emphasize waiting for backup, rather than engaging alone. Policy should specify that officers shall wait for backup before physically approaching any involved subject(s), unless an officer reasonably believes there is a substantial risk of bodily injury to any person(s).**

4. I've previously noted other potential recommendations (e.g. implementing a predictive early intervention system, on top of the IAPro system, by collaborating with University of Chicago's Data Science for Social Good program). I sent you all a compilation of some potential recommendation on 3/1/2017.

One potential recommendation of particular merit that I'd like to again point out. The Police

Executive Research Forum (the premier U.S. policing think tank) has developed a wonderful set of guidelines for reducing the number of deadly force incidents.

Last week, Herman Goldstein (the internationally famous originator of Problem Oriented Policing – a Professor Emeritus at UW Law School, who happens to live right here in Madison) and Cecelia Klingele (also of UW Law School) provided testimony to the Ad Hoc Police Review Committee. One point that was emphasized was, that if there's only one thing committee members should read in full, it should be PERF's 30 Guiding Principles on Use of Force. I've attached a copy to this e-mail.

A potential recommendation:

> **Issue: The rate of officer involved shootings has been increasing in Madison over the last two decades. Very few of these incidents involve an active shooter. The Police Executive Research Forum has developed a set of 30 principles to provide officers with guidance and options, and to reduce unnecessary uses of force in situations that do not involve suspects armed with firearms.**
>
> **Recommendation: The Council will direct the Chief of Police to implement in full the Police Executive Research Forum's Guiding Principles on Use of Force.**

5. I don't have much to add at this point regarding the "Oversight of Internal Investigations" and "Communication with City Council" recommendations in your draft. They both seem appropriate. Perhaps you may wish to add a bit more detail to the "Oversight of Internal Investigations" recommendation.

Sincerely,

Gregory Gelembiuk
Amelia Royko Maurer
Nathan Royko Maurer

2

Dear CCOC Subcommittee members,

Given the presentation and discussion at the last CCOC Subcommittee meeting, I would suggest adding a recommendation to implement a predictive early intervention system. The remainder of the letter discusses the relevant issues, and at the end I include some potential draft language for such a recommendation.

It has long been known that in most police departments, a relatively small proportion of officers are responsible for the bulk of adverse incidents.

For example, see the FiveThirtyEight article: "How To Predict Bad Cops In Chicago". Excerpt:

> *...department data on complaints against officers obtained through a legal challenge shows that police misconduct in Chicago is overwhelmingly the product of a small fraction of officers and that it may be possible to identify those officers and reduce misconduct...*
>
> *Repeaters only make up a small fraction of the more than 12,000 officers on Chicago's force — perhaps 1 percent to 10 percent of the officers in the database, depending on where you draw the line — but are responsible for a huge fraction of the complaints: 10 percent of the officers who had received complaints generated 30 percent of the total departmental complaints since 2011. The 10 individual repeaters with the most complaints in the past five years averaged 23.4 complaints against them in that span....*
>
> *A data-driven mechanism to reduce police misconduct would be extremely valuable to the Chicago Police Department and the city of Chicago. Even laying aside the moral imperative to prevent abuse, the financial cost of police misconduct to the cash-strapped city is immense. Direct costs, in terms of legal fees and the funds disbursed in settlements, exceeded $500 million over 10 years, according to a Better Government Association study. The McDonald case alone was settled for $5 million.....*
>
> *I found that the number of complaints an officer receives in a certain year predicts whether and how many complaints he or she will have in the following year. Over multiple years, the signal becomes even stronger. Officers with a baseline history of one or two complaints in 2011-13 have a 30 percent to 37 percent chance of receiving a complaint in the following two years. But repeaters — those with 15 or 20 incidents in the first part of the data set — are almost certain to have a complaint against them in 2014-15.*
>
> *Spokesmen for the police have explained the high complaint totals of repeaters as a consequence of the "bad neighborhoods" to which some officers are assigned. The logic goes that under constant harassment and threat of violence, police may behave more aggressively (albeit still within the boundaries of the rules) and therefore be accused more frequently of misconduct. After considering the beat an officer was patrolling, I found that some neighborhoods did see an increased number of complaints. Even after*

controlling for neighborhood, however, individual officers with more complaints in 2011-13 remained more likely to have complaints filed against them in 2014-15.

From the Las Vegas Review Journal article "Troubles follow some officers who fire their guns on the job":

> *Involvement in an on-duty shooting isn't necessarily a sign of a troubled officer. Sometimes shootings go with the job, and some of the department's most respected officers have shot at people.*
>
> *But the propensity of troubled officers to shoot has been shown in at least two studies based on internal police records. One, by The RAND Corporation in 2008, looked at the New York Police Department. A year later, Los Angeles County examined its sheriff's office.*
>
> *"It is absolutely legitimate," said Samuel Walker, a professor at the University of Nebraska at Omaha and author of The New World of Police Accountability. "Any time there's a controversial incident, look at that officer's history."*
>
> *Law enforcement experts say police departments need effective early warning systems to identify cops who are sloppy or whose actions in minor incidents presage bigger -- and perhaps more deadly -- things to come.*
>
> *Walker said that police have realized a small number of officers account for a large share of problems.*
>
> *"Historically, the dirty little secret in policing is that police know who the problem officers are," Walker said.*
>
> *In one of Las Vegas' biggest police scandals, some officers knew who the problems were. That information just took too long to get to the top.*

It's known that officers who are involved in one questionable officer involved shooting (e.g. Steve Heimsness' parking garage shooting, Matt Kenny's shooting of Ronald Brandon, etc.) are far more likely to be involved in additional shootings subsequently.

We now have algorithms that can identify officers at high risk of misconduct, involvement in officer involved shootings, etc. This allows intervention (for example, retraining, reassignment to different tasks, etc.) before tragedy strikes.

As I noted in a prior letter to your committee (and as was discussed in your last meeting):

> University of Chicago Data Science for Social Good (DSSG) program will partner and work with police departments to develop superior predictive early intervention systems - systems that use statistical modelling or artificial intelligence approaches to actually predict officers most at risk of adverse events. Such systems provide continuous risk

scores rather than binary flags, can incorporate information on differences between neighborhoods and shifts, and provide a large improvement in sensitivity and specificity.

As one of the DSSG data scientist noted:
"By the end of the summer, our top-performing model (a variation on a Random Forest) was able to correctly flag 80% of officers who would go on to have an adverse interaction, whilst only requiring intervention on 30% of officers in order to do so. Although this was just a first pass, if we had been using a threshold-based system as has been used in other police departments, we would have needed to flag 2 out of every 3 police officers in the department for the same level of accuracy."

Perhaps even more importantly, officers in the top 1% of risk scores for the DSSG system accounted for a full 30% of subsequent adverse incidents. In other words, intervening with only a handful of officers identified by such a system (e.g. ~5 officers for a department Madison's size) could enable a substantial reduction (e.g. 30%) in adverse incidents. Meanwhile, a system that flags half the force annually for intervention would likely be ignored. See Chicago for an example of an intervention system that has been nominally implemented, but that is not functioning as intended.

Here's a paper by DSSG on its police early intervention system work, and here's some additional information (including video presentations). So far, DSSG has developed early intervention systems for the Charlotte-Mecklenburg and Nashville Police Departments.

Furthermore, it's crucial that all relevant data be in used as input for the early intervention system. It's critical not to, for example, exclude data from prior years, unsustained complaints, etc. If you exclude such information from the system, you're deliberately setting up a system designed to find nothing. From the Chicago Reporter article "Program that flags Chicago cops at risk of misconduct misses most officers":

Like many law enforcement agencies, the Chicago Police Department has an early intervention system that is supposed to flag officers at risk of serious misconduct and provide them with training and support to get on the right track.

But of 162 Chicago police officers with 10 or more misconduct complaints in the past four years, just one was enrolled in the department's program as of October, according to a Chicago Reporter analysis of data obtained through a Freedom of Information Act request.

An officer is eligible for the program if he or she receives two sustained complaints or three excessive force complaints within 12 months, though they can also be

recommended for the program based on a pattern of complaints. Less than 4 percent of all complaints filed against CPD officers are sustained.
Overall, there were just 11 officers enrolled in CPD's two primary early intervention programs, out of more than 12,000 sworn officers in the department—the nation's second-largest law enforcement agency.

"Those numbers defy belief," said Samuel Walker, an emeritus professor at the University of Nebraska, and a leading national expert on police early intervention systems. "It says the system isn't working and is designed not to work."

It's no wonder, experts said, that the system failed to effectively intervene before Officer Jason Van Dyke, who had 19 citizen complaints and two misconduct lawsuits against him, shot and killed 17-year-old Laquan McDonald in October 2014....

One of the problems with CPD's system, experts said, is that it can't consider unfounded misconduct complaints or complaints that are more than five years old, a requirement of the police union contract.

Nationally, only about 10 percent of police misconduct complaints are sustained, said Dennis Kenney, a professor at the John Jay College of Criminal Justice in New York. "If you are excluding 90 percent of complaints right off the top, then you have a flawed early warning system," he said.

A high number of prior complaints, even those that are not sustained, is a strong predictor of future misconduct complaints, according to a recent analysis of Chicago police complaint data by the data-journalism website FiveThirtyEight.

None of the complaints against Van Dyke was sustained, and most of them were too old to make him eligible for the intervention programs....

"To have a truly robust [early intervention] system, you want to have as much information as possible," said Ilana Rosenzweig, the former head of Chicago's independent police oversight agency....

Even with the best data, early intervention doesn't work without supervisors who are willing and able to identify the underlying problem that causes the behavior and find the right intervention to address it, experts said.

"What really counts is the mindset of the people running the program," Walker said. "Is there a tendency to excuse the officer's behavior? Or is it to say, 'I think there's something wrong here, we need to look deeper?'"

Chicago's small number of enrolled officers indicates that supervisors are using the program as restrictively as possible, rather than actively trying to intervene when an

officer's behavior seems awry, Walker said.

Including unsustained complaints is especially important in a case like MPD's. MPD officers incur citizen complaints at a rate comparable to other major cities (e.g. the rate of excessive force complaints is identical to that for New York City). However, MPD internal investigations sustain citizen complaints, and especially excessive force complaints, at a very aberrantly low rate – even lower than the sustain rate for the Chicago Police Department (where the failure of the latter to ever sustain complaints is considered a national scandal). In early 2013, after Paulie Heenan was shot, I looked at the data and found that In 2008-2012, MPD sustained only one out of 108 citizen complaints of excessive force, a sustain rate for excessive force complaints that is 8.6 times lower than the national average. Excluding all the unsustained complaints would produce an early intervention system incapable of identifying the officers truly in need of intervention.

Here's some potential draft language for a recommendation:

Early Intervention

Issue: Some officers are at disproportionate risk of adverse incidents. Most major city police departments have implemented early intervention systems. Such programs identify at-risk officers and allow early intervention to avert adverse incidents.

Recommendation: MPD should implement a program for early intervention. MPD should collaborate with University of Chicago's Data Science for Social Good program to implement a predictive early intervention system. The system should be designed to maximize accuracy in predicting risk of adverse incidents and should utilize any data needed for this purpose, including all complaints, even those not sustained, and information from officers' long-term history. Furthermore, for officers identified as requiring intervention, the type and intensity of intervention must be sufficient to fully ameliorate the increase in risk.

Sincerely,

Gregory Gelembiuk
Amelia Royko Maurer
Nate Royko Maurer

3

Dear CCOC Subcommittee members,

I'm writing with yet another suggestion: that your committee recommend that MPD conduct root cause analysis of officer involved shootings.

Since its inception, the Community Response Team has been discussing and advocating the need for root cause analysis of MPD officer involved shootings. Michael Bell, whose son was killed in a Kenosha officer involved shootings has also been advocating this, often referencing the need for NTSB-type investigations. David Couper has also advocated for the implementation of such analyses.

A root cause analysis dissects an adverse event to determine its fundamental causes, enabling learning and corrective action to minimize the risk of further such events and improve public safety. It takes a system-level perspective, and is an accepted technique for guiding continuing quality improvement in complex organizations. Its use is institutionalized in medicine (where it's commonly referred to as sentinel event review), in transportation accidents (where such analyses are conducted by the National Transportation Safety Board), in crime labs, and in many other contexts. For example, a determination that all policies were followed, and that no-one was legally culpable, is not considered an adequate conclusion for an NTSB investigation of an airline accident. Rather, the point is to understand the fundamental causes of the crash, to enable development and implementation of measures to prevent any additional crashes.

Here's an explanation of the concept – from "Reviewing Police Use of Force Through Root Cause Analysis" in RegBlog (a forum for regulatory news and analysis).

> *More recently, law enforcement and criminal justice agencies across the country have begun to embrace a new type of event review, one in which the primary focus is not on blame or punishment, but rather on the creation of a "just culture" of learning, understanding, and education. These "just culture" event reviews go by various names, but whether they are described as root cause analyses or sentinel event reviews, their philosophy is the same: when our law enforcement system generates undesirable events, we should review those events first to understand the true underlying causes of why events unfolded the way they did and how the events could have been avoided, rather than reviewing them to understand who is responsible and should therefore be blamed or punished.*
>
> *Policing is a complex activity, with multiple people involved in fast-paced, dynamic reactions to incomplete information in a high-stress and high-stakes environment. In such a system, it is inevitable that things will not always go as intended. As the National Institute of Justice has noted, organizational accidents "are rarely the result of a single act or event. In medicine, aviation and other high-risk enterprises, serious errors are regarded as system errors or 'organizational accidents.' Organizational accidents are potential 'sentinel events,' incidents that could signal more complex flaws that threaten the integrity of the system as a whole."....*

By contrast, the future is precisely the focus of a sentinel event review, a "nonblaming, all-stakeholder, forward-leaning mechanism—to go beyond disciplining rule-breakers in an effort to minimize the risk of similar errors in the future and improve overall system reliability." Such investigations, epitomized in other industries through structures like health care's morbidity and mortality reviews or the National Transportation Safety Board, have a very different set of priorities by seeking to learn how to prevent the next error, rather than to hold participants of the last error accountable.

Such reviews are not focused on blame or discipline. Rather, they begin from the perspective that virtually no police officer wants to use force on civilians, nor do civilians wish to have force used on them. The question then becomes why the confrontation occurred despite the goals of all involved at the outset. We are no longer arguing about who should be blamed, and instead we are discussing how well-intended people on all sides of the undesired interaction could have avoided the confrontation, while still keeping our communities safe.

See also "How Transportation Safety Review Can Play a Role in Regulating Law Enforcement" for additional discussion of this concept in the context of law enforcement. One useful point to note: *"Often system-level factors that contribute to unwanted outcomes are only apparent after aggregating across multiple incidents, each of which appear unique and idiosyncratic when viewed in isolation."*

Also see here for an article about the National Institute of Justice Sentinel Event Initiative.

Since the 1970's, NYPD has been analyzing officer involved shootings by NYPD officers, with the point of reducing such shootings. The lessons learned from its causal and statistical analyses have enabled it to reduce its per capita rate of officer involved shootings to one of the lowest for any major city in the nation.

From the 2014 NYPD firearms report:

"Department records all officer-related discharges, whether purposeful, accidental, or, more rarely, criminal, as well as discharges of a police firearm by a third party. Analysis of this data over more than four decades has indelibly altered the way that officers respond to, engage in, and assess the need for firearms discharges. By making oversight manifest, the Department has made it clear that each and every discharge is a matter of immediate concern. When recordkeeping began in 1971, 12 officers were shot and killed by another person, and 47 officers were shot and injured. In turn, officers shot and mortally wounded 93 subjects, with a further 221 subjects injured by police gunfire. In 2014, by contrast, two officers were shot and killed by another person, and six were injured (three by gunshot), while police shot and mortally wounded eight subjects and injured 14. Information gleaned from these reports has initiated a Department-wide

tactical, strategic, and cultural shift with regard to how officers use and control their firearms. The Department has made restraint the norm.

Today, these reports serve as a statistical engine for the development of training, the adoption of new technology, and the deployment of Department resources. New instructional scenarios are implemented as a result of this analysis and new hardware—from bullet-resistant vests to conducted energy weapons—has been introduced."

Richmond, CA is another city that has dramatically reduced its rate of fatal officer involved shootings. A point of note (from the article "Use of deadly force by police disappears on Richmond streets"):

"[Chief] *Magnus has done something in Richmond that he believes is not done enough in other departments: He's been willing to second-guess the deadly force used by other cops.*

"We use a case study approach to different incidents that happen in different places. When there is a questionable use-of-force incident somewhere else, we study it and have a lot of dialogue," Magnus said. "It's a model that is used in a range of other professions, but in some police circles, it's seen as judging in hindsight and frowned on. In my mind, that attitude is counterproductive.""

Likewise, the Police Executive Research Forum notes:

"Learning from incidents is not "second-guessing": In the aftermath of a controversial shooting by an officer, it is not unusual to hear police say, "The officer had to make a split-second decision; we shouldn't second-guess that decision." And it is true that police often must respond quickly to complex situations. However, it is not "second-guessing" to learn from tragic incidents in order to prevent the next incident from happening. This is how police departments learn, develop new policies and tactics, and take lessons from each other."

And importantly, President Obama's Task Force on 21st Century Policing has recommended the widespread implementation of such reviews.
"2.3 TASK FORCE RECOMMENDATION: Law enforcement agencies are encouraged to implement non-punitive peer review of critical incidents separate from criminal and administrative investigations."

In its response to this task force recommendation, MPD states: *"MPD CURRENT STATUS: MPD uses a review process that is codified in the SOP Proficiency, Continuous Improvement & After Action Reports. It is believed that MPD can only improve processes through a continuous review of our performance."*

That's great spin. Superficially, it sounds fine. However, if you actually look at the *"Proficiency, Continuous Improvement & After Action Reports"* SOP, 1. It does not actually implement root

cause analysis, and 2. does not specifically reference officer involved shootings (or "critical incidents").
It's referencing an After Action Report to be filled out after certain events. The only real analysis called for is as follows:
"Critical Analysis of Identified Issues: This section analyzes the issues raised during the tactical debriefing. The issues evaluated should be based on the exercise objectives. It should be organized by objective and should address each objective, including those that were performed as expected. Each issue write-up should be organized as described below.
Recommendations for Future Improvement: This section should detail out any and all ideas so as to improve future MPD proficiency and operational effectiveness."

In no way is this an actual root cause analysis. And it's really not designed to address officer involved shootings.

Moreover, I'll note that when analysis aiming to understand and reduce officer involved shootings becomes institutionalized in a police department, it can generate a long-term decline in such shootings (as occurred with NYPD). Once such analysis becomes part of the institutional bureaucracy of the department, and the department is figuring out for itself how to improve the problem, taking on the objective as its own, the department owns the process and internal recommendations, generating buy-in.

Here's some potential draft language for a recommendation:

> **Root Cause Analysis**
>
> **Issue: Understanding the root causes of officer involved shootings can enable corrective actions, including changes in training and policy, to reduce the risk of recurrence of such events. Root cause analysis is a method of problem solving used for identifying the root causes of adverse events. It's an accepted technique for guiding continuing quality improvement in complex organizations. President Obama's Task Force on 21st Century Policing has recommended the widespread implementation of such reviews: "Law enforcement agencies are encouraged to implement non-punitive peer review of critical incidents separate from criminal and administrative investigations."**
>
> **Recommendation: MPD should implement a mechanism for thorough and credible root cause analysis of officer involved shootings. These would be non-punitive reviews, separate from Professional Standards investigations assessing potential policy infractions. The objective of such reviews would be to identify the root causes of officer involved shootings, in order to develop measures to reduce the risk of such shootings, and attendant mortality and injury, to the greatest extent possible. Root cause analysis should be performed on each individual officer involved shooting, and on the aggregate of such events over time.**

For a more detailed understanding of the terms "thorough and credible" in the context of root case analysis, see here and here.

Sincerely,

Gregory Gelembiuk