The In-Custody Death of Robert Ramirez:
Independent Review of the
Oxnard Police Department's Investigation and Review

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Introduction

On June 23, 2012, officers from the Oxnard Police Department (OPD) responded to a call for service regarding an individual who had reportedly swallowed a large amount of methamphetamine and was acting erratically. OPD officers responded and eventually took the man to the ground. It took several minutes for officers to subdue the man, later identified as Robert Ramirez; during that time he repeatedly expressed that he was having difficulty breathing. The six OPD officers and one sergeant involved used control holds, a police baton as a leverage device, their own body weight, handcuffs, and a foot restraint device to take Mr. Ramirez into custody. After he was handcuffed, Mr. Ramirez was treated by paramedics and transported to the hospital where he was eventually pronounced deceased. The County Medical Examiner (ME) found the cause of death to be restraint asphyxia. He also found the presence of methamphetamine intoxication.

OPD's Major Crimes Unit investigated this incident and presented its findings to the District Attorney's Office, which declined to file charges against the involved officers, finding their actions to be legally justified. On the Department's initiative, the matter was also presented to the Federal Bureau of Investigation which determined that a federal civil rights investigation into the matter was not warranted. OPD also conducted an administrative investigation, which similarly found no violations of policy with regard to the actions of its officers. The decedent's family members brought a civil rights action in federal court which resulted in a verdict in favor of the plaintiffs, with a large award of damages.

While the investigation into this matter was still in its early stages, the Chief of Police of the City of Oxnard approached OIR Group and requested that we conduct an independent review of the incident. This report constitutes the results of that review. This review is not intended to second guess the determinations by the District Attorney, OPD, the FBI, or the federal jury with regard to the conduct of the involved officers. Nor is this review intended to wade into the debate and controversy regarding the ME's determination as to cause of death. Rather, this investigation is intended to examine and evaluate the investigations of the incident conducted by OPD and its subsequent administrative review.

While this report assesses the thoroughness of OPD's investigation and the robustness of the Department's systemic internal review process, it is intended to be a vehicle for

moving the Department forward. To that end, we offer recommendations intended to improve the OPD's investigative and review processes. The report also puts forward ways that OPD could improve protocols and policies to provide further guidance to its officers and better prepare them to respond to future similar events, something that neither the District Attorney's opinion nor the federal jury verdict is designed to do.

In addition to engaging OIR Group to complete this review, OPD conducted its own rigorous review of both the criminal and administrative investigations into this critical incident. That review identified a number of areas where the investigative response could have been improved. More importantly, OPD developed a robust after-action plan that was tailored to systemically remediate the investigative issues identified during the review process. In our work in this field, we have reviewed numerous critical incident investigations and never have seen the rigor of critique and depth of self-initiated efforts to improve the investigative process that we saw in OPD's internal review of this event. OPD's own work on this incident could serve as a model for the kind of self-assessment that law enforcement agencies should complete following any critical incident.

The Department's own efforts to review this incident and identify areas for reform led to a number of policy changes, training developments, and other systemic improvements that will leave its officers better prepared for any similar future challenges. Nonetheless, our review identified additional issues and recommendations for corrective action – with both the investigation and the administrative review of the involved officers' performance. What we found most lacking in the internal investigation was a sufficiently deep dive into the involved officers' actions once Mr. Ramirez was taken to the ground, using the contemporaneous audio recordings to more precisely detail, document, and assess those actions. With regard to OPD's administrative review, we found that the performance of the involved officers and their specific actions after the takedown as well as their activities as a group should have at least been the subject of additional Department discussion, assessment and analysis.

The most important thing a police agency can do in response to a tragic outcome is to learn from it – to perform an exacting investigation and review so that the organization and its officers can be better trained and equipped to deal with tomorrow's circumstances. The Department has done a remarkable job of this on its own, but the fact that the Chief of Police and City officials commissioned this additional, independent review is further testament to a City and Police Department committed to transparency and reflection. We could not have completed this review without the full cooperation of the OPD. During our visits to Oxnard and throughout the review period, we received unfettered access to documents and decision makers, and each police official with whom we visited spoke

with candor about the incident. Consistent with that perspective, we expect that the Department will thoughtfully consider the recommendations we offer here, and are hopeful that our review will provide another opportunity for introspection for the Department, so that it can continue to refine and improve the way it investigates and reviews critical incidents.

Investigative Issues

In our years of experience, we have yet to see a "perfect" critical incident investigation – careful review can always identify areas for improvement. Yet it is rare for a law enforcement agency to review a critical incident investigation with such intent. In this case, OPD did perform a thoughtful review and to its credit, identified a number of flaws in the investigation as well as in the Department's investigative protocols. Most importantly, after identifying the issues, the Department revised policies and devised training mechanisms designed to address those flaws and improve the Department's response to future critical incidents. The following are the investigative issues identified by OPD and their blueprint for remedying them.

Lack of clarity regarding OPD investigative response to incident

When the OPD's Investigations Services Bureau was first contacted regarding the Ramirez matter**,** there was confusion about whether detectives would respond to investigate the incident since Mr. Ramirez was still alive at the time and OPD's policy manual in effect at the time did not expressly designate this as a critical incident requiring a detective response.

During its review of the incident, OPD determined that it needed to provide more clarity regarding whether OPD detectives should handle similar future incidents. As a result, OPD modified its policy manual to broaden the definition of critical incidents to include any case in which a person is admitted to the hospital as a result of police action, and now instructs that such incidents will be investigated by the Department's Major Crimes Unit. The policy modification will provide more certain guidance regarding the lead investigative unit responsible for investigating similar incidents and ensure that a greater number of force incidents resulting in significant injury will receive a heightened level of investigation by the Department's detectives.

Video camera not available to capture critical incident

When practicable, it is advantageous that police actions of this nature be captured on video. To its credit, OPD recognized this principle during its after action review. At the time of the incident, however, there was no expectation that field personnel video record such incidents. Moreover, patrol personnel had only one camera available for use, which was not on scene. As a result of OPD's after-action review and recommendations, OPD purchased eight video cameras to be assigned to patrol sergeants with the plan to eventually equip all patrol sergeants with video equipment.

In addition, OPD created a policy provision entitled: "Video Cameras Assigned to Patrol Supervisors." While the overall policy is generally well-considered, the policy instructs as follows: "On-scene supervisors shall have the option to delegate the use of a video camera to another officer or Department employee, in order to facilitate the appropriate supervision at the scene." While this language is helpful guidance to sergeants, if there is only one supervisor on scene, that individual's sole role should be that of incident commander, not the self-designated videographer. For that reason, we recommend the language in the policy be modified to more specifically instruct supervisors to delegate the responsibility of video-taping the incident to other personnel so that the sergeant can oversee, coordinate, and supervise the operation.

> *Recommendation 1: OPD should consider modifying its policy regarding video cameras to instruct supervisors to delegate any videography function to other OPD personnel when the supervisor is acting as the on-scene incident commander.*

Involved officers participated in initial canvass and interviews

After a police action, it is a standard investigative practice to assign non-involved responding officers to canvass the area for potential witnesses and conduct interviews of any witnesses. In this incident, officers who used force were involved in both the canvass and interview of witnesses. In critical incident investigations, other than providing a brief statement to arriving supervisors, involved officers should not be assigned further on scene tasks and should be transported to the station by uninvolved officers. However, because as explained above, there was initial confusion about whether this incident was to be handled as a critical incident, involved officers were assigned canvassing and interviewing tasks. During its after-action review, OPD identified this issue and Major Crimes investigators provided corrective briefing training to all patrol officers regarding this topic.

Moreover, and to its credit, to institutionalize this concept, the OPD implemented a revision order in December 2014 addressing this issue. Oxnard Policy 300.7 now reads: "Ensure all witnesses are located, identified, and interviewed by uninvolved officers. This may be accomplished through a canvass of the area."

Inadequate witness canvass by responding officer

During the canvass of the neighborhood, officers contacted one residence with multiple occupants. A non-involved responding officer reported that he was advised by the occupants that a party was in progress and that nobody had seen or heard anything about

the arrest. However, contrary to witness canvass protocols and training, the officer did not obtain a list of persons present at the residence or any personal or other locator information. Days later, OPD investigators returned to the residence and were eventually able to locate a number of party attendees who were witnesses to the incident. However, because of the failure of the initial canvassing officer to obtain locator information the night of the incident, the follow up investigation proved significantly more time-consuming and most likely not optimally effective in identifying all possible civilian witnesses to the incident.

OPD recognized the problems with the witness canvass performed by this officer and recommended that he be provided remedial training on how to properly conduct a canvass and document his actions in a report. OPD further recommended that all sworn personnel receive training reminding them how to conduct a canvass and the need to fully document their actions.

The after action memorandum reported that Major Crimes Investigators provided a briefing to all patrol officers with regard to this topic. A separate memorandum indicated that the supervisor responsible for implementation of OPD recommendations met with the particular officer for thirty minutes and reviewed with him how to properly conduct and document a canvass. During the remedial instruction, the officer reported to the supervisor that since the incident, he had been spoken to about the topic by at least two other supervisors and a detective regarding the importance of the witness canvass.

Photographs of involved officers could have been better

An important component of any critical incident investigation is to document through photographs any potential evidence and the scene location. Routinely included in this set of photographs are those of the involved officers, showing how they looked immediately after the incident, the equipment they were wearing at the time of the incident, and any observable injuries suffered during the incident. During the administrative review, it was discovered that the photographs of the officers were not consistent and did not capture all of the equipment they were carrying nor their duty belts. It was also noted that the photographs did not include the nametag or a placard for identification purposes.

As part of the after action of this critical incident, a procedural checklist was provided to all OPD Field Evidence Technicians and Major Crimes investigators detailing procedures on how to properly photograph officers involved in critical incidents.

Identification of leading questions used during interviews of involved officers

During supervisory review of the OPD detective's interview of four of the involved officers as well as the internal affairs interviews of the three remaining involved officers[1], several questions were identified as "leading" and examples of leading questions were set out in the report. Leading questions are questions designed to help guide the witness to a certain answer that the interviewer expects. Investigative practices teach that during the fact gathering phase of an investigation, it is preferable to ask open-ended questions where the witness supplies the information, not the interrogator. This is particularly the case in investigations of police conduct since there already may be a natural tendency for the investigators to anticipate what might be in the mindset of a fellow police officer and supply those answers in the questioning process.

To its credit, OPD command staff responsible for review of the detective and internal affairs investigations recognized the potential deleterious impact of using leading questions during critical incident investigations. As noted in the administrative review, when conducting an interview of an involved officer, the interviewer should ask open ended questions in the beginning to solicit a narrative response. The OPD review stated that the interviewer should allow the officer to detail what occurred, the officer's observations and what actions the officer took in response. The OPD report adeptly noted that once an investigator interjects leading questions in an interview of an officer involved in a critical incident, it could be interpreted by some that the investigator is "force feeding" answers to the officer and demonstrates bias through the investigator's attempt to assist the officer during the interview.

The supervisors who identified the use of leading questions recommended that OPD provide training to the teams of officers responsible for both the criminal and administrative interviews regarding the negative consequences of the use of leading questions during fact gathering interviews. OPD further recommended that the investigators' supervisors be tasked with closely reviewing interviews of officers involved in critical incidents to prevent inculcation of the practice.

In response to the recommendation, a supervisor met with the investigators involved in the critical incident investigation and briefed them on the issue. In order to export the

[1] As detailed elsewhere in this report, four of the involved OPD personnel provided voluntary statements while three declined to do so and were thus compelled to provide administrative interviews.

training issue more broadly, Oxnard Major Crimes investigators provided training to all patrol officers with regard to the topic.[2]

In our work with numerous other agencies, we have reviewed internal investigations that had officer witness interviews rife with leading questions, and our reports frequently remind those departments of the importance of avoiding such questions. However, this is the first time in our experience where the police agency itself identified leading questions during its investigative review and took actions designed to remediate the issue. Oxnard is to be commended for having supervisors attuned to the issue, with the orientation towards candid and constructive self-criticism of the Department's own work product, and the willingness to both identify the problematic questions and then address the issue with fellow police personnel.

Use of investigative aids to understand officers' actions and movements

During the OPD investigation, investigators provided the involved officers a diagram of a prone individual so that they could identify their positions as well as the positioning of fellow officers during the force incident. The use of such diagrams can be of extreme advantage in helping form a visual record of positioning and movement that mere words cannot as easily do. OPD, however, went a step further to suggest that a mannequin be acquired so that the officers' actions and positioning could be even more evident and visual. As a result, the Major Crimes Unit was tasked to explore options regarding the purchase of a mannequin which could be used in future cases. Eventually, it was determined that OPD had defensive tactics training equipment that could be used to satisfy the intent of the recommendation. OPD should be credited for its interest in developing ways to improve its visual record of a critical incident through use of investigative aids such as diagrams and mannequins.[3]

The failure to timely interview emergency personnel

During its review of the incident, OPD learned that responding emergency aid personnel were not timely interviewed with regard to their actions and observations. The OPD

[2] It is unclear from the Oxnard after-action report how and whether the recommendation that supervisors review critical incident interviews of involved officers to ensure that leading questions are not used was to be integrated into supervisory protocols.

[3] We have used mannequins to good effect in creating a visual record of involved officers in force incidents. If a mannequin were to be used during the interview however, any demonstration by the involved officer should be video-taped and the officer's narrative audio-taped so that a permanent record of the demonstration is captured.

reviewers recognized the important information that first responders might have with regard to observations on scene, the condition or actions of any individuals provided medical treatment, and any statements made by them or involved officers about the incident. As part of the after action report, it was recommended that in future cases, detectives or patrol officers interview emergency care responders as soon as practical after a critical incident. In order to implement this recommendation, Major Crimes investigators provided training to all patrol officers with regard to this matter.

While OPD is to be commended for the robustness of its review of the critical incident investigation and investigative practices and the development of a comprehensive action plan designed to address each issue identified, we identified additional issues specific to the Ramirez investigation regarding the Department's investigative practices:

Failure to sufficiently consider police audio recordings of incident

As indicated in the OPD reports, five of the seven involved officers recorded the incident on their department issued digital audio recorders.[4] Audio recordings of a critical incident such as this is of crucial importance, as it may capture contemporaneous statements and present sense impressions by the officers and the person with whom they are dealing, record sounds of physical distress by the person being taken into custody, or provide evidence of the force being used by the officers. While the OPD reports contain brief encapsulations of some of the statements heard on the audio recordings and snippets of one of the recordings, there was significant underuse and analysis by investigators of the audio evidence available to them.

While OPD appropriately transcribed the interviews of the involved officers, it failed to fully transcribe the audio recordings of the event made by the officers.[5] In contrast, the ME, in his death investigation report, transcribed most of the tape recordings and created a timeline for the statements and sounds. However, likely because the ME was not personally familiar with the responding officers, the ME's report does not attribute most of the statements to any particular officer making them. If OPD investigators had prepared transcripts, they would have likely been more successful than the ME in

[4] At the time of the incident, OPD's policy did not require its officers to record such events. To OPD's credit, since the incident, OPD policy was changed to require officers to activate their digital audio recorders during such incidents.

[5] The detective investigation contains brief summaries of the tape recordings and a detailed time line with some of the recorded statements included. The administrative investigation contains a brief snippet of one of the tape recordings but there are no comprehensive transcripts of each of the involved officer audio recordings by OPD.

determining which involved officer made which statements. Without transcripts of the recordings included in the OPD investigative reports and the attribution of the statements to individual officers, reviewers were required to listen to the actual tape recordings in order to evaluate and assess the audio evidence, a significantly more arduous task.

More significantly, during their interviews of the involved officers, OPD investigators failed to ask them about statements made at the time of the incident and captured on audio recordings. If the officers had been asked about specific statements they made or were in a position to hear, they would have been prompted to explain the statements and their accounts of the incident likely would have been more detailed. Moreover, by explaining the statements they made, the involved officers would have been able to provide more clarity on precisely what they were observing and doing at various times throughout the incident.

Indeed, there were a number of comments captured on tape that the involved officers should have been asked about. For example, at several points, Mr. Ramirez is heard stating, "I can't breathe." These comments drew several reactions from involved officers including one officer saying: "Let him breathe," and another officer instructed Mr. Ramirez to relax and breathe. Other officers are heard saying, "hold on, he's not breathing," while another officer stated, "he's holding his own breath," "he doesn't want to breathe on his own" and "he's not really that unconscious." Considering that the ME ruled the cause of death to be asphyxia, the importance of these statements is obvious. It was critical that investigators determine how the involved officers assessed Mr. Ramirez's condition at the time they were taking him into custody and what, if anything, they attempted to do to relieve or address the situation. Investigators should have asked the officers about the statements they made while the incident was unfolding.

Other statements captured on tape that investigators should have followed up on were the comments made by officers regarding force options being used during the incident. For example, one officer is heard asking other officers to assist him in determining when it might be appropriate to engage the Taser. At one point, an officer is heard to say to another officer "can you sit on that leg?" At another point in the incident, one officer instructs other officers to "drop a knee over there." There is also officer discussion about the use of the body wrap that is audio recorded and should have been the basis for follow up questioning.

The failure of OPD to question the involved officers about statements they made during the incident resulted in a less clear picture of what occurred. Moreover, asking officers to explain statements they made at the time of their encounter with Mr. Ramirez could have

resulted in more questions being raised about the officers' performance during the incident.

OPD raises a pragmatic but important point about the interrelationship between Recommendations 2 and 3 in this report. If protocols are modified so that an interview account of the incident is obtained from the involved officers the night of the incident, transcripts of any audio capture of the incident would not be available to use during the officers' interviews. In order to overcome these practical impediments, best practices teach that detectives briefly review any audio or video capture of the circumstances leading up to the incident and the incident itself and then interview the involved officers based on that review as well as any other information developed during the first few hours of the investigation. As the investigation proceeds, OPD should then have relevant portions of any audio accounts of the incident transcribed and if a review of that transcription or any other information subsequently developed during the investigation suggests additional questions, re-interview the involved officers with respect to that additional information.

> *Recommendation 2: When there is audio evidence that captures statements of involved officers and/or statements of the person being taken into custody, OPD should prepare transcripts of that audio evidence and use the statements during their interviews of involved officers.*

Failure to obtain contemporary accounts from the involved officers

Four of the officers involved in the incident agreed to a voluntary interview but the interview was not conducted until three days after the incident. Three of the officers declined to provide voluntary interviews so were compelled to answer questions posed by internal affairs investigators ten days after the incident. The failure to obtain a statement from the involved officers the night of the incident is inconsistent with best investigative practices. It is apparent that OPD investigators are aware of the importance in obtaining a contemporaneous statement by the fact that a number of civilians identified as witnesses to this incident were interviewed within a few hours of the incident. However, the involved officers – those most knowledgeable and whose conduct was being reviewed – were not interviewed until at least three and up to ten days after the event.[6]

[6] Clearly, civilian witnesses are differently situated than Department members since the willingness and availability of civilians to participate may change over time. But there are similar reasons for timely interviewing civilian and officer witnesses as well, namely, both could

By agreeing to this delay in interviewing the officers, the investigation forfeited the opportunity to obtain pure contemporaneous statements from the involved officers about what each did and why they did it. While the investigative machinery worked hard to obtain contemporaneous and pure statements of observations from civilian witnesses, the investigative protocols allowed the involved officers' versions to be subject to contamination and recall issues as a result of the passage of time or exposure to other accounts of the incident from media sources, legal representatives or fellow officers. Moreover, to the degree that the investigation is an organic exercise, any leads or further investigation that might be derived from the involved officers' version of events were delayed until the statements were acquired.[7]

Some police officer advocate groups have pointed to memory studies which suggest that memory improves after an individual has had an opportunity to de-stress, sleep, process the event before being called upon to provide a recollection as a reason to afford officers up to three days delay before being interviewed. Those advocates, however, undervalue the competing factors detailed above, including the potential for conscious or unconscious contamination during the wait period. Moreover, because in this case, three of the officers were not interviewed until well past the optimal 48 to 72 hour window suggested by these advocates, any advantage to waiting some period of time was lost as a result of the additional passage of time. Finally, if police agencies were to accept this premise as paramount, they should likewise delay the preparation of written police report and the collection of witness, victim, or suspect statements after any event. This clearly would not be consistent with accepted police investigative practices, which teach that subjects, victims, and witnesses should generally be interviewed as soon as they are identified.

Some have questioned whether the real reason for such a delay is to afford the officers the opportunity to either consciously or subconsciously choreograph or tailor their responses with the help of external influences or exposure – in other words, "to get their

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be advertently or inadvertently exposed to external information that could affect their recollection if a pure statement is not obtained from them the night of the incident.

[7] In OPD's after-action review, it recognized that those officers who declined to provide voluntary statements should have, per policy, written police reports setting out an account of the incident before leaving their duty assignment. However, in this case, it may have been uncertain which officers were inclined to provide voluntary statements on the night of the incident since the voluntary interviews were not conducted until three days after the incident. Moreover, as detailed elsewhere, police reports are an inadequate substitute for a wide-ranging and thorough interview of involved personnel.

stories straight." While there is no evidence that such was a motivating factor in this case, the fact that some community members will believe it to be true is damaging to the credibility of the police agency and its investigation.

In reality, the delay may not afford the officers any advantage whatsoever and may call into question the usefulness of their delayed statements because of the likelihood of memory contamination or memory loss. In talking with officers involved in critical incidents, many have expressed their desire to timely provide their account of what occurred and have reported that any delay may be counterproductive to their interest in telling their account in a timely fashion and their ability to provide an accurate and useful account.

Consistent with normal investigative practices, OPD should obtain contemporaneous statements from all officers involved in critical incidents.[8]

> *Recommendation 3: OPD should modify policy and protocols so that involved officers in a critical incident are requested to provide voluntary statements to investigators before ending their shifts. If the officers decline to provide voluntary statements, OPD administrative investigators should compel an interview before releasing the officer from duty.*

Failure to interview police witness to the incident

In the Ramirez incident, an OPD sergeant arrived on scene and observed part of the force used by the involved officers. While the sergeant wrote a detailed police report noting his observations and actions, he was not interviewed as part of the OPD investigation. In critical incident investigations, it is imperative that all police personnel who are witnesses to the incident be interviewed. Police reports cannot substitute for a full-blown thorough interview as a report contains only the information that the writer of the report deems relevant. Moreover, unlike an interview, a police report does not allow for immediate follow up questioning or provide a mechanism for directing the witness' attention to a particular part of the incident. OPD should have interviewed the responding sergeant contemporaneously with the incident.[9]

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[8] Of course, in the instance where an officer is significantly injured as a result of the critical incident, there should be some leeway in the application of the protocols to allow for medical treatment and physical recovery. In this case, there were no such extenuating circumstances.

[9] The sergeant witness was eventually interviewed by an investigator from the Office of the District Attorney but not until ten months after the incident.

Recommendation 4: OPD should modify its investigative protocols for critical incidents to ensure that any percipient police witnesses to such an event are interviewed contemporaneously with the incident.

Documenting voluntary transport of witnesses

The OPD reports indicate that the Department transported civilian witnesses to the police station for further questioning. The environment of a police station is sometimes more conducive to such interviews and it is standard practice to transport witnesses for more detailed interviews. However, some police departments have been subjected to civil payouts as a result of allegations that witnesses to critical incidents were detained and transported to the station against their will. In order to insulate the agency from such claims, a number of departments have promulgated protocols and training that instruct its officers to either obtain a signature from any witness to be transported to the station that the transport is voluntary and/or obtain oral consent on tape.

To its credit, at the time of the incident, OPD had policy addressing this potentiality at the time of the Ramirez incident. Officers were instructed per that policy to obtain a "written, verbal or recorded statement of consent prior to transporting a witness in a department vehicle." After the Ramirez incident, the policy was further clarified to instruct officers that "if transporting witnesses, obtain his/her permission (audio recorded if possible).

It would have been helpful in reviewing the investigative report if the witness summaries of those individuals transported to the police station reflected that per policy consent was obtained and how it was done.

Recommendation 5: OPD should develop protocols that ensure that the Detective summary reports of civilian witnesses transported to the police station include documentation that they were done so consistent with the Department's witness transport policy.

Failure of investigator to visit the scene prior to conducting interviews

A review of the investigative materials indicated that one of the detectives who conducted interviews relating to the critical incident interviewed at least one witness without having visited the scene. Because knowledge of the scene and movement of the involved individuals is so important in a critical incident, it is crucial that those personnel tasked with interviewing witnesses should visit the scene and ideally, obtain a briefing and/or walk through of the incident from an OPD supervisor familiar with the

preliminary facts gathered about the incident. Such a scene "walk-through" will provide the interviewer with necessary context when those being interviewed provide their accounts of the incident.

> *Recommendation 6: OPD should develop protocols that instruct its detectives that it is imperative that they travel to the scene and obtain a brief walkthrough and/or briefing from OPD personnel familiar with the preliminary facts before conducting any witness interviews.*

Investigator unfamiliar with equipment used

One of the detectives assigned to interview the involved officers commented that he was not familiar with the operation of the Taser or the foot restraint used during the critical incident. Detectives assigned to conduct use of force investigations must be familiar with each force option and all equipment used during the operation, so that well-grounded questions can be formulated and the interview does not become a tutorial on the mechanics of the force option for the investigator.

> *Recommendation 7: OPD should ensure that detectives assigned to critical incident investigations have distinct familiarity with the force options and equipment deployed during the incident.*

Public release of the 911 call

Several days after the incident, OPD released the recording of the 911 call that formed the basis for the police response to the location. The caller described the actions of Mr. Ramirez. Several Oxnard community members questioned the public release of the recording and were critical of the Department's motives in the selective release of information.

When a police agency determines to release selective evidentiary information about a critical incident, it subjects the organization to public criticism. For that reason, Department protocols with regard to release of such information should be clearly defined and consistently applied. If there is a preexisting policy, for example, that media requests for 911 calls will be presumptively granted, the Police Department has written authority to release such calls. If however, the protocols provide the Department unfettered discretion on whether to release emergency calls for service, it will leave OPD subject to criticism for using that discretion inappropriately.

> *Recommendation 8: OPD should develop written protocols governing whether and when to publicly release the recordings of 911 calls.*

Review Issues

As detailed above, it is essential that a critical incident is investigated thoroughly so that the District Attorney can accurately assess the matter and Departmental decision makers have the best set of facts available to ensure accountability of its officers and to transform the incident into a teaching moment for the organization. But ensuring objective and complete fact gathering through well-defined investigative protocols and procedures is only step one. It is also essential that a law enforcement agency implements procedures that ensure a robust and critical review of the incident so that officer performance can be effectively evaluated and any lessons to be learned from the incident can be exported back to the involved officers, their supervisors, and all Department personnel. A key goal of this process is to make the agency's officers better able to address future similar challenges.

Again, we found that the OPD review mechanisms that followed this critical incident were more robust than the responses of other police agencies facing similar situations. Like the improvements and action plans for investigative issues, OPD's after action review and systemic reforms coming out of this incident were remarkable in their scope. Most similarly sized agencies do little more than a paper review with no attention toward systemic learning and reform. In contrast and as detailed below, OPD's review process for this incident resulted in numerous improvements in the way in which the Department does business. While our review identified additional issues worthy of systemic review and reform, OPD deserves credit for its after-action review. Its systemic reform efforts following this incident could serve as a model to law enforcement agencies wishing to adopt similar progressive policing principles.

Readers may ask why, if OPD's after action mechanisms were so robust, a federal jury found against the involved officers. Our assessment of OPD's review and reform effort does not extend to an assessment of the officers' performance, the issue the jury was required to adjudge. When an agency is oriented toward learning and improving from an incident, the performance of its officers in future incidents will improve accordingly. Moreover, as we set out below, while OPD performed a thorough systemic review, that degree of scrutiny and assessment unfortunately did not extend to its review of either the individual or concerted performance of the involved officers.

Training bulletins to guide officers handling similar situations

Following this incident, OPD issued a series of training bulletins that provided detailed guidance to its officers on how to respond to persons exhibiting similar signs of distress. Laudatory features of the training bulletins included:

- The need for officers to develop a tactical plan, when feasible, prior to taking action.
- The advantage of having an officer trained in crisis intervention on scene when possible.
- The advantage of obtaining as much information as possible regarding the subject's condition or history before initiating action.
- The need to designate one officer to make contact using clear and concise commands in a calm and non-confrontational manner.
- If a decision is made to physically control the individual, the interest in doing so safely and quickly.
- The emphasis towards placing body weight on limbs as opposed to the torso of the individual.
- The discouragement of pain compliance techniques such as baton strikes and chemical agents.
- The discouragement of using the Taser in drive stun mode.[10]
- Increased responsibilities of field supervisors to coordinate the response.

The detailed training bulletins crafted by OPD following this incident provide important guidance to its officers regarding how to approach and handle future calls for service involving persons who are exhibiting similar signs of distress. The emphasis on planning, supervision, and resolution are important lessons to impart to its officers.

Field supervisor unnecessarily involved in the tactical response

OPD's after action review noted that when the decision was made to make physical contact with the individual, one of the seven officers on scene was a sergeant who was physically involved in the group effort to subdue the person. Considering the amount of other resources available on scene, OPD's reviewers recognized that it is tactically preferred that the on-scene supervisor not become involved in direct negotiations or part of the hands-on response. Rather, the supervisor should take the role of incident commander, standing back and overseeing the entire incident and providing instructions

[10] The use of the Taser in drive stun mode does not incapacitate individuals but merely inflicts pain.

and guidance to the tactical team as necessary. As part of the after-action, this principle was discussed with the involved sergeant. In addition, the issue was addressed with all OPD field sergeants at a briefing of first level supervisors.

Improving delivery of medical care to persons taken into custody

During its after-action review, OPD learned that emergency medical providers were actually on scene prior to the arrival of first responding officers. However, it was standard protocol at the time for rescue personnel to "stage" a short distance from and out of the line of sight from the incident until the individual was safely taken into custody. OPD's review of this critical incident caused it to reconsider and reflect upon the protocols then in effect. As a result, the Department disseminated a training bulletin that suggested emergency medical personnel should be notified of the situation, involved in the development of the tactical plan, and physically on-scene to immediately evaluate the subject once he is safely in custody. The Department issued a training bulletin that detailed the procedures by which the on-scene supervisor would brief rescue personnel and devise an alternative approach of having emergency medical personnel staged closer to the scene – with protection, if necessary – for a more rapid response.

In February 2014, to further ensure timely medical care to persons taken into custody, OPD provided training related to a newly adopted Rescue Task Force Program which provides a coordinated response to violent incidents where rapid lifesaving medical care and evaluation of patients located in a hazardous area is required. This curriculum was developed by a combined Ventura County fire and law enforcement group and was in direct response to the Aurora Theater shooting incident of 2012. The intent of the training is to instill recognition in the fire community that they may sometimes need to provide life-saving medical care before a situation has been entirely resolved and with the assistance of law enforcement, finding a way to do so.

Like OPD, more police agencies are recognizing the need to rethink the traditional relationship between police and emergency rescue personnel and to create ways for medical assistance to be provided to wounded, injured or otherwise distressed subjects as quickly as possible. We commend the County in general and the City of Oxnard in particular for recognizing that the traditional paradigm of having rescue routinely stage off scene until all is entirely stable may no longer be sufficient to meet public expectations and to devise new responses that still keep rescue safe but allow for a quicker medical delivery system.

Review of Involved Officer Performance

Failure to consider critically officers' performance

A significant shortcoming of OPD's review of this incident was the lack of a candid, detailed, and dispassionate review of the involved officers' performance either individually or as a group. While OPD did identify issues emanating from its review process and took remedial actions, including issuing training bulletins designed to improve the knowledge set of its officers in dealing with persons exhibiting similar signs of distress, the assessment of the involved officers in the incident itself was shallow and cursory. For example, the review of officer performance did not consider whether any of the involved officers unnecessarily placed body weight on the individual's torso, contrary to the best practices set out in OPD's subsequently published training bulletin. In addition, the review did not consider whether involved officers appropriately responded to the individual's repeated claim that he could not breathe and was articulating signs of increased distress or whether those distress signs were disregarded because the individual was, in fact, breathing.[11]

The review also did not consider whether the officers sufficiently developed a plan and whether they effectively and efficiently carried out that plan. For example, the officers' audio recording of the incident indicated that at one point, an officer instructed others to "drop a knee." Because these recordings received insufficient attention, it is not clear whether any officer heeded that instruction; regardless, the instruction itself should have been subjected to additional scrutiny during the review.[12] Another consideration not articulated during the review was whether having six officers going hands on with a prone individual was a tactical deployment of too many resources. Similarly, the investigation revealed that one of the involved officers was briefly tangled up in the device eventually used to restrain the individual's feet but the review contained no analysis of this potential problem.[13]

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[11] Our review of other in custody death cases has found other occasions where the statement "I can't breathe" has been tragically misunderstood by other officers; it should obviously be interpreted as "I am having difficulty breathing."

[12] As noted above, insufficient attention was given to the audio recorded statements made by the involved officers and Mr. Ramirez during the use of force.

[13] It is also concerning that this fact is not included in the summary of the involved officers' statements.

The review also did not spend sufficient time and analysis regarding officer decision making that was consistent with training and Departmental expectations and worthy of positive reinforcement. For example, when the initial two officers arrived on scene, one officer went to assess the individual in distress while the other attempted to gain more information about the situation from those who had prompted the call. Moreover, and to their credit, the initial responding officers called for backup and a sergeant to respond to the location. This and other exemplary decision making should have been set out in OPD's analytical review.

This is also true with regard to actions of the involved officers that may have been commendable once Mr. Ramirez was taken to the ground. For example, one of the involved officers reported that he observed that the weight of a fellow officer was making it difficult for him to secure his arm and he asked that officer to reduce his pressure on the man. Another officer is heard on tape advising fellow officers to watch the man's head and keep it from making contact with the ground. And, as reported above, the audio recordings reveal an unidentified officer telling his fellow officers to let the man breathe.

In sum, the most disappointing shortcoming of OPD's review of this incident was failure to critically review the involved officers' performance either individually or as a group. That evaluation should have considered whether that performance could have been improved in any way, even if it was considered with the advantage of hindsight. A cursory conclusion regarding such performance is not helpful and unlike the good critical work OPD displayed in its systemic review, it fails to move the Department and its officers forward in any productive, educational and remedial way.[14]

We have been informed that since the Ramirez review, OPD has developed a tactical review protocol. The review is intended to encompass the following responsibilities:

- A subject matter expert is assigned to conduct a tactical review
- The tactical review is intended to supplement the administrative review and
    - Identify policy violations

[14] The fact that the District Attorney declined to prosecute is of little moment to what should be a more exacting analysis and critique by OPD. First, the District Attorney reviews the incident with regard to potential criminality and is not engaged in a detailed critique of the performance of the officers based on administrative standards. Moreover, in this case, the District Attorney did not have available all of the information possessed by OPD since three officers failed to provide voluntary statements and the District Attorney is precluded from using compelled statements in evaluating the officers' conduct.

- Identify policies and procedures that can be improved upon – "Lessons learned
- Hold employees accountable for policy violations through training and/or the discipline process
- Assign specific personnel to implement any recommended policy and procedural change
- Track and ensure the completion of the recommended change

We are heartened but not surprised that OPD developed and engineered a tactical review process prior to us recommending they do so. As we have said elsewhere, that self-initiative and interest in critique and improvement is a threat we have repeatedly seen during our review of this incident.

> *Recommendation 9: During its tactical review, OPD should continue to perform a detailed critique of every involved officers' performance and analyze the tactical decision making from the time the call is received until the incident is concluded.*

The lack of a robust documented feedback loop to involved officers

As noted above, an essential component of any progressive critical incident review is to ensure that the Department as a whole and the involved officers in particular understand how the Department's expectations were and were not met during the incident. While we have noted above that OPD performed extraordinarily in exporting some of the lessons learned back to its members, the record is less clear with regard to the degree to which Department command staff transformed the incident into a teaching moment for those officers who were actually involved in the incident. While we have noted above some efforts to provide individual feedback to members, e.g., the on-scene sergeant taking a tactical role rather than one of command, there was no apparent systemic debriefing of each of the involved officers to discuss the critical incident review findings. Ideally, at the end of the process, a supervisor intimate with the critical incident review would sit down with each involved officer and lead a discussion about the challenges of the incident. This discussion should include things the officer did well – the decision making and tactical performance that was proficient and consistent with Departmental expectations – as well as those areas where the officers' performance could have been better or where an alternative approach might, in the future, lead to a better outcome.[15]

[15] Sometimes officer performance is so contrary to policy and Departmental expectations that an internal affairs investigation and potential discipline is in order. The feedback loop described in this section is not intended to address those situations that involve potential violations of policy.

Such a briefing allows the insight the Department has gained about the critical incident to be transferred to the involved officer in a constructive and meaningful way.

> *Recommendation 10: OPD should develop protocols to ensure that every officer and supervisor involved in a critical incident receives a personalized and detailed briefing regarding any insights gained from the critical incident review process.*

Conclusion and Recommendations

Following this tragic incident, OPD performed a thoughtful and sustained review of the incident with regard to the investigation and investigative protocols which resulted in a number of remedial actions. OPD's systemic review also resulted in training bulletins that will leave its members better prepared to address similar challenges in the field. However, OPD's review of individual officer performance and the force incident in total was not rigorous, forfeiting the potential for additional learning. We are expectant that OIR Group's additional recommendations with regard to the Department's investigative protocols will be considered by OPD as ways in which its critical incident investigative response can be further improved. Finally, we hope that following future critical incidents OPD will use the same critical scrutiny that it directed towards its investigation and systems issues in evaluating the performance of the officers involved. OPD's resolve toward a rigorous critical incident review process makes us optimistic the Department will take heed do so.

The following is a list of all recommendations presented in this report.

1. OPD should consider modifying its policy regarding video cameras to instruct supervisors to delegate any videography function to other OPD personnel when the supervisor is acting as the on-scene incident commander.

2. When there is audio evidence that captures statements of involved officers and/or statements of the person being taken into custody, OPD should prepare transcripts of that audio evidence and use the statements during their interviews of involved officers.

3. OPD should modify policy and protocols so that involved officers in a critical incident are requested to provide voluntary statements to investigators before ending their shift and if the officers decline to provide voluntary statements, compel an interview before releasing the officer from duty.

4. OPD should modify its investigative protocols for critical incidents to ensure that any percipient police witnesses to such an event are interviewed contemporaneous with the incident.

5. OPD should develop protocols that ensure that the Detective summary reports of civilian witnesses transported to the police station include documentation that they were done so consistent with the Department's witness transport policy.

6. OPD should develop protocols that instruct its detectives that it is imperative that they travel to the scene and obtain a brief walkthrough and/or briefing from OPD personnel familiar with the preliminary facts before conducting any witness interviews.

7. OPD should ensure that detectives assigned to critical incident investigations have distinct familiarity with the force options and equipment deployed during the incident.

8. OPD should develop written protocols governing whether and when to publicly release 911 calls.

9. During its critical incident review, OPD should perform a detailed critique of every involved-officers' performance and analyze the tactical decision-making from the time the call is received until the incident is concluded.

10. OPD should develop protocols that ensure that every officer and supervisor involved in a critical incident receives a personalized and detailed briefing regarding any insights gained from the critical incident review process.