Independent Board of Inquiry Into the Oakland Police Department

March 21, 2009, Incident

A Public Report of Findings and Recommendations

Prepared for the Independent Board of Inquiry

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Note: This is an Independent Report, and it does not reflect the official position of the City of Oakland or the Oakland Police Department. The Board of Inquiry raised issues and questions that required additional investigation to obtain a comprehensive assessment into the circumstances contributing to the tragic outcomes of March 21, 2009. As a result, important lessons were learned.

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Executive Summary

On Saturday, March 21, 2009, the suspect, who was a parolee recently released from prison, murdered four Oakland Police Department (OPD) veteran personnel. This incident was the deadliest occurrence in the history of the OPD and one of the most significant law enforcement losses in the State of California and the nation.

Acting Chief of Police Howard Jordan ordered that an independent review be conducted to understand how this happened and what can be done to prevent a future recurrence. Acting Chief Jordan convened a board of outside experts to review the facts and circumstances surrounding the March 21, 2009, Incident. The Board of Inquiry (BoI) was composed of senior leaders from outside agencies who were considered experts in tactical procedures and in investigating large-scale critical incidents. In order to inform their findings and recommendations, the BoI reviewed hundreds of pages of documents, audio tapes, interviews of involved personnel, Homicide Section and Internal Affairs Division investigatory reports, as well as all other pertinent evidence and circumstances relative to the incident. The BoI also convened on several occasions by teleconference and video conference and met in-person for 3 days of hearings. The purpose of this BoI was to identify the factors contributing to the tragedy, develop findings on specific actions and decisions, review the use of force, and provide a set of recommendations (advisory and non-binding) to better inform and help the executive leadership within the OPD and overall law-enforcement professional community identify potential improvements in procedures, training, and tactics.

Incident Summary

The March 21st incident evolved in four inter-related phases: 1. The Vehicle Stop – Officer Down, 2. City-wide Response/Command, Control and Coordination, 3. Identifying and Securing the Suspect's Location, and 4. Dynamic Entry/Use of Force/Officer Down. The officers and suspect in this public report are not identified by name, as requested by the OPD, but have been provided with a number or other designation. The Timeline of Events is included at the end of the Incident Summary (page 9).

The Incident Context

Area III, where this incident occurred, has reported a disproportionate share of the city's violent crime − gangs and active felons operate in a highly mobile environment. Area III has recorded multiple incidents of violent crimes in and along the section of Macarthur Boulevard where the traffic stop and the murder of the Traffic Sergeant and Traffic Officer took place on March 21, 2009.

1. Vehicle Stop − Officer Down

The incident began at 1:00pm on Saturday, March 21, 2009. It began as a routine traffic stop along Macarthur Boulevard, when Motorcycle Sergeant #1 notified police radio and provided the license plate and driver's license for a standard Department of Motor Vehicles (DMV) records check. Motorcycle Officer #1 joined Sergeant #1 as a cover

officer. Sergeant #1 was notified by police radio that the DMV reported there was "no record on file" for the driver's license. Soon thereafter, as Traffic Sergeant #1 and Traffic Officer #1 approached along the driver's door side together, the driver leaned out the driver's side window and methodically shot (1:15pm) each officer twice. Neither officer had drawn his service pistol. The suspect crawled out the driver's side window and walked to the dying officers, shooting each in the back as they lay face down in the street. The suspect then turned and fled on foot, west on Macarthur Boulevard and was last seen running onto 74th Avenue southbound.

As the suspect fled, some community members rushed to help the wounded officers. They gave comfort and first aid, and called 911 for immediate emergency medical and police assistance. Citizens applied CPR to the seriously wounded officers until the arriving police units relieved them.

2. City-wide Response/Command, Control, and Coordination

The responding units (1:17pm) quickly provided medical support, preserved the scene, identified witnesses, and began a search for the murder suspect. In less than one minute the suspect description was broadcast to responding police units ("suspect is a male black, 5'8", 150 pounds, all black clothing, light skinned, wire rimmed glasses, direction of flight southbound on 74th..."). The first Sergeant (1:19pm) on-scene made a situational assessment and quickly notified radio that enough officers were on scene and that other responding units should begin to look for the suspect. A containment perimeter was initiated, and police self-assigned roles to staff perimeter posts. The Area III watch commander, Lieutenant #1, was on-scene within 3 minutes (1:19pm) and began to attempt to impose some order on the developing chaos. Lieutenant #1 immediately expanded the emergency response by ordering a city-wide call for all units to respond (1:19pm). Lieutenant #1 then called the immediate superior (off-duty) and notified Captain #2 of the unfolding critical incident.

The city-wide Officer-Needs-Help broadcast caused more than 115 police units from OPD and many outside agencies to respond to the crime scene. The watch commanders from Area I (Lieutenant #2 @ 1:23pm) and Area II (Lieutenant #3 @ 1:31pm) responded rapidly as well. The two met briefly two blocks from the crime scene, without Lieutenant #1, and Lieutenant #3 decided that incident management roles should be de-centralized. Lieutenant #3 assumed responsibility to plan and coordinate the suspect search, while Lieutenant #1 managed the crime scene and Lieutenant #2 coordinated the perimeter, attempting to unsnarl the jumbled traffic. No command post was established, and the city-wide response overwhelmed the on-scene commanders, with many responders self-assigning their own activities. It would be 90 minutes before senior OPD leaders (e.g., captains and deputy chiefs) arrived on-scene.

3. Identifying and Securing the Suspect's Location

At the homicide scene, evidence technicians searched the suspect's vehicle for his true identity. Police Evidence Technicians recovered a California Department of Corrections (CDC) number and were following up with a computer search of databases to identify the

suspect and obtain his photograph and other pertinent data. The suspect was identified, and copies of his most recent photograph were printed and ready for distribution before the suspect's likely location was identified and the order to make entry into the apartment was given. However, this information and the suspect's photograph were not distributed due to the lack of overall incident coordination.

The suspect's likely location was obtained by Lieutenant #1, who personally identified an eyewitness. This eyewitness stated that she actually saw the suspect, after the shooting, being admitted into the apartment building at 2755-74th Avenue by a female. This eyewitness was known to Lieutenant #1 as highly credible, but additional corroboration was sought.

Sergeant #2, an Area I supervisor, planned to obtain additional corroboration of the suspect's location using a certified tracking canine to follow the suspect's escape route from his vehicle as far as the scent led. Lieutenant #1 approved this plan, and Sergeant #2 arranged for an Alameda County Sheriff's Office (ACSO) canine team to respond with an expected arrival in 45 minutes.

Numerous pieces of information related to the suspect's location were being developed independent of Lieutenant #3, who self-assigned as coordinating the suspect search. Another Lieutenant (#4), who was off-duty, received information that a highly credible confidential informant (CI) reported the suspect's location as 2755-74th Avenue. Lieutenant (#4) was called by Lieutenant #3, who advised that he was coordinating the suspect search. Lieutenant #4 told Lieutenant #3 that the suspect's location was in the ground floor front apartment at 2755-74th Avenue. Lieutenant #3, without consultation or coordination with Lieutenant #1, ordered a SWAT Team callout (1:49pm) via police radio.

Lieutenant #3 next met briefly with Lieutenant #4 and the CI one block from the suspect's location. Lieutenant #3's confidence in the information provided by the CI was low since the CI didn't personally see the suspect enter the apartment. Lieutenant #3 overrode Lieutenant #4's assessment that the CI was credible and discounted the CI's information. Since Lieutenant #3 had not coordinated with Lieutenant #1, who had an eyewitness who actually saw the suspect enter the apartment, Lieutenant #3 was missing key corroborating evidence regarding the suspect's location.

However, Lieutenant #3 did order a sergeant to form a containment perimeter around the apartment building at 2755-74th Avenue. The Bearcat, an armored SWAT vehicle, was parked in front of the suspect's apartment location, in view of the front apartment windows. At the same time another sergeant formed a team of officers to canvass both sides of 74th Avenue, south from Macarthur Boulevard, where the suspect had been observed fleeing. Lieutenant #4 had to order the canvassing officers to take cover, since the suspect was probably in the front ground floor apartment facing the street. There was no overall shared situational awareness regarding the suspect search developments among the on-scene commanders and sergeants. Since basic emergency incident management protocols were not being followed and no command post had been established, there was

no centralized point for the collection and dissemination of intelligence. This was likely a significant contributor to the lack of communication and continued confusion.

At 2:38pm, Lieutenant #3 acknowledged that the ACSO tracking dog was minutes away from Sergeant #2 and his team's location at 75th Avenue and Ney. However, Lieutenant #3 made an independent command decision that the plan to use tracking dogs was too dangerous and that the apartment at 2755-74th Avenue had to be entered and cleared before it would be safe enough to use the tracking dog. The full SWAT Team had yet to arrive; there were no Hostage Negotiators, Snipers, or Tactical Operations Support Team members on-scene − although their arrival was expected momentarily. Lieutenant #3, nonetheless, ordered an ad hoc Entry Team to be formed from SWAT Team officers and supervisors on-scene, an action contrary to Departmental policy.

Sergeant #2, ordered by Lieutenant #3, transitioned from canine coordinator to SWAT Team member and, together with other Tactical Team Leaders, formed the ad hoc Entry Team with SWAT Team supervisors (five) and members (three)[1].

4. Dynamic Entry/Use of Force/Officer Down

The ad hoc Entry Team moved from 75th Avenue and Ney to behind the cover of the Bearcat in front of 2755 – 74th Avenue. At approximately 2:50pm, Lieutenant # 3 met with the arriving senior command personnel. The briefing included a Deputy Chief (who, by OPD policy as the highest ranking officer, becomes the Incident Commander). Also present were Captain #1, the Tactical Commander, Captain #2, Area III Commander, and Lieutenant #1. Lieutenant #3 held the briefing in the middle of the intersection at 74th Avenue and Macarthur Boulevard (in the line-of-sight of the suspect apartment). Shortly thereafter, the plan was briefed to enter and clear the apartment at 2755-74th Avenue, as a precaution, using just the ad hoc Entry Team. According to Lieutenant #3's assessment, the threat was considered very low since he believed that it was highly unlikely the suspect was present.

At one point, the Deputy Chief asked the assembled command staff whether they felt a search warrant was required for forced entry into the apartment. The staff replied that in their opinion no warrant was required because the entry constituted fresh pursuit. This fact was particularly troubling to the members of the Board of Inquiry, in that it contradicts statements indicating that the staff felt there was a low probability that the suspect was present in the location of interest. If the staff truly believed there was little probability of the suspect's presence, there could be no fresh pursuit exemption from the warrant requirement.

Captain #1, the Tactical Commander, deferred to Lieutenant #3's plan to enter and clear the apartment without objection, question, or comment. Captain #1, then asked the Deputy Chief "Are you OK with this?" The Deputy Chief concurred, but asked Captain

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[1] The SWAT Team automated alert notification had not yet been activated to call in Hostage Negotiators, Snipers, Entry Team members, and the Tactical Operations Support Team. This was a serious failure that delayed the arrival of key tactical elements by 45 minutes, just after the actual moment of dynamic entry.

#1 if medical support had been staged nearby, which reminded the Captain to do so. Instead of recognizing the absence of one of the most fundamental steps in tactical planning, Captain #1 allowed the tactical plan to move forward.

Lieutenant #1 stated that during the briefing in the middle of the intersection, Lieutenant #1 provided information from the eyewitness who saw the suspect being let into the 2755-74th Avenue apartment building by a female. This information had been corroborated by a CI with Lieutenant #4, but Lieutenant #1 stated that the senior commanders disregarded the relevance of the information. Lieutenant #1 then departed the briefing and returned to the duties as crime scene commander. The collective decision was then made to move forward immediately with the ad hoc Entry Team.

The ad hoc Entry Team moved into position at 3:02pm. The suspect's door was forced open and Sergeant #4 entered first, followed by Sergeant #3. As Sergeant #3 entered, he was mortally wounded. Sergeant #4 was shot and wounded in the shoulder. The Entry Team had not yet fired a shot, unable to identify a target, and they continued to move into the poorly illuminated front room.

Unexpectedly, a female started screaming and emerged from the bathroom (the general direction from where the shots were being fired at the police), and ran past the oncoming Entry Team. Surprised Entry Team members alerted on her as a possible shooter but held their fire while they assessed the threat she posed as she ran yelling past them into the outer hallway. Sergeant # 3 was evacuated while Sergeant #4, suffering from a gunshot wound, continued forward into the bathroom. Toys and tricycles were present in the apartment front living area and rear bedroom.

An Entry Team member, Officer # 2, observed the suspect beside a rear bedroom door holding an assault weapon. Officer #2 fired at the suspect as he retreated into the bedroom and closed the door. Entry Team members pressed forward and forced the closed rear bedroom door partially open. As Entry Team member Sergeant #2 passed into the bedroom he was mortally wounded. The second Entry Team member to enter the room was Sergeant #4. As he rushed into the room, he tripped in the dim lighting conditions, and fell in front of the suspect, who was seated on the floor inside the closet concealed by the partially open door. As Sergeant #4 fell he may have been struck by a bullet fired by the suspect, but it was deflected by his armored helmet. While on the floor in front of the suspect, Sergeant #4 could see the suspect holding an assault rifle with a large capacity magazine and a bayonet fixed on the end of the barrel. Sergeant #4 fired at the suspect in defense of his life and the lives of other team members. At the same time, Officer #2 came around the door and fired at the suspect. Officer #2 had been joined by ACSO Deputy #1, who had rushed in from the perimeter to assist the Entry Team. ACSO Deputy #1 also fired at the suspect. Once it was determined the suspect was no longer a threat, the assault rifle was removed from his reach. The two fatally wounded SWAT Team members were evacuated and transported to the hospital.

The incident ends with four OPD personnel murdered and the suspect pronounced dead at the scene. This is the greatest tragedy in OPD history and one of the worst in the State of California and the nation.

General Assessment

The March 21st incident was the deadliest encounter in the history of the Oakland Police Department. As a result, five lives were lost, one sergeant was wounded, and many police officers and citizens were exposed to potential life threatening injury. This incident began with a routine vehicle stop and escalated with the murder of two officers and a city-wide response. This critical large-scale incident required coordinated efforts among many OPD units and several outside agencies. The first responders, mostly limited to Area III personnel, arrived at the scene quickly and took self-assigned actions that were outstanding.

However, the newly promoted and inexperienced Area III watch commander, Lieutenant #1, did not establish a command post or implement any basic emergency incident management protocols. The decision by Lieutenant #1 to order a city-wide response brought more than 115 units and the two other Area watch commanders to the scene. The three Lieutenants failed to coordinate their efforts and plans. Instead, the Area II watch commander, Lieutenant #3, self-asserted overall command and inexplicably decentralized the command of the large-scale critical incident into three separate and uncoordinated activities. The Area III watch commander, Lieutenant #1, immediately called the more experienced supervisor, Captain #2 (who was off-duty), but the call lasted less than a minute and no further contact was made until Captain #2 arrived 90 minutes later. Overall, officers, supervisors, and outside agencies did not have shared situational awareness; a command post was not established, they did not understand their roles in the massive search for the suspect, they had no knowledge of an overall plan to manage the 115 units arriving at the scene, and they did not know who the Incident Commander was. This lack of coordination contributed to an ineffective and poorly managed operation.

The search for the suspect was uncoordinated and not managed appropriately by Lieutenant #3. This resulted in further deterioration of the command decision making. Lieutenant #3, although not declaring so, assumed the role of Incident Commander, without consultation with the crime scene commander, Lieutenant #1, who, according to statements from numerous supervisors on-scene, was effectively managing the unfolding incident. Lieutenant #1 had obtained an eyewitness who saw the suspect enter the apartment building at 2755-74th Avenue, an essential piece of information concerning the suspect's location. Lieutenant #3 acted, independently from Lieutenant #1, as the undeclared Incident Commander by assigning command roles, decentralizing command responsibility, calling for a SWAT Team callout, and making the decision to send the ad hoc Entry Team members in to enter and clear the apartment. However, Lieutenant #3 only completed a small portion of the Incident Commander role, leaving most tasks unaddressed and uncoordinated. He failed to establish a command post, staff it appropriately, or implement even the most fundamental elements of the Incident Command System (ICS).

The decision to enter and clear the ground floor front apartment at 2755-74th Avenue was problematic from its inception. Lieutenant #3 did not gather routine intelligence on the target location, establish location surveillance, or obtain an interior floor plan and building layout. Lieutenant #3 made no attempts to contact the occupants of the suspect apartment using a telephone, public address system, or throw phone. No efforts were made to protect the surrounding residences, no evacuations were attempted, and no background information was gathered for the location in preparation for the enter-and-clear operation. Lieutenant #3 next self-assigned himself the role as de facto Tactical Commander, ordering that an ad hoc Entry Team be formed from amongst the team members present rather than waiting for the full SWAT Team, a violation of OPD policy.

The SWAT Team callout procedures were not appropriately carried out by Lieutenant #3, and the actual SWAT Team notification was delayed for 45 minutes. Independent of the responding SWAT Team elements, Lieutenant #3 formed an ad hoc Entry Team – expressly prohibited by OPD General Orders. He then ordered the ad hoc Entry Team, without Sniper Support, Hostage Negotiator assistance, or Tactical Operations Support to engage in the high-risk operation of entering and clearing the suspect's apartment. Lieutenant #3 developed the plan to enter and clear the apartment without consultation with all of the ad hoc Entry Team members. He inappropriately discounted the possibility of the suspect's presence inside the apartment. Lieutenant #3 denied the mounting evidence being developed by other lieutenants from credible witnesses and reliable sources as to the presence of the armed and dangerous suspect.

The enter-and-clear plan exhibited flaws, and it should have been terminated during a competent review by senior leaders. Lieutenant #1, according to a recorded statement, told the gathered senior commanders that a highly credible eyewitness placed the suspect in the apartment building in association with another female shortly after the murder of the two police officers. In addition, another CI reported to Lieutenant #4 that the suspect was in the ground floor front facing apartment. Rather than stop a flawed plan, the Tactical Commander, Captain #1, and the deputy chief (Incident Commander) approved Lieutenant #3's plan.

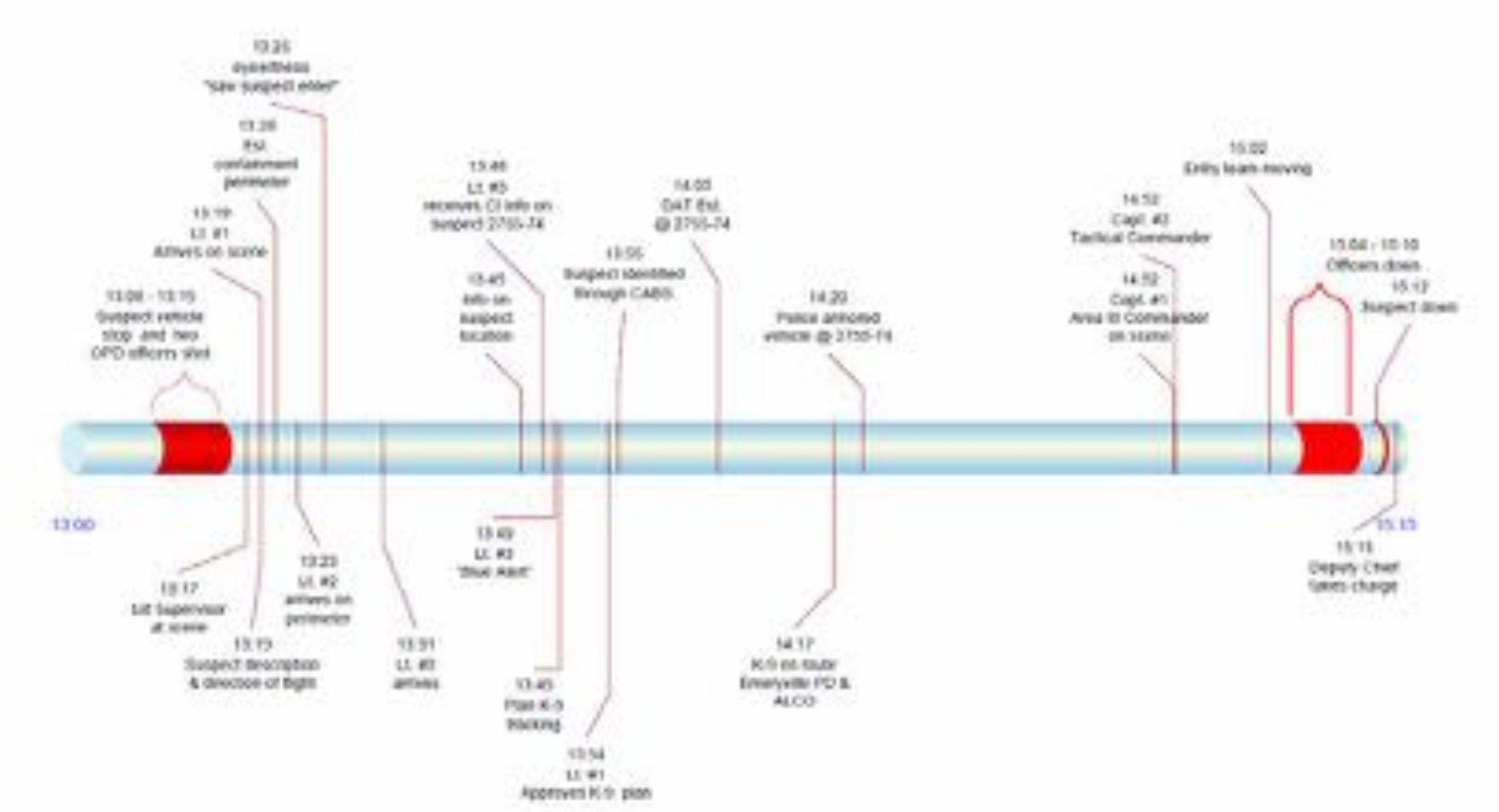
Once approval was given, Lieutenant #3 met with the ad hoc Entry Team and provided a limited and rushed briefing. It is worthy of note that not all Entry Team members were present for the briefing in its entirety. After the briefing, there were many unaddressed issues. For example, some of the Entry Team members did not know who the team leader was. Neither was there time for adequate discussion among the Entry Team members regarding searching protocols and possible contingency plans (i.e., response to shots fired or an officer-down, and the designation of a safe rally point).

The use of lethal force did not occur until after the ad hoc Entry Team had forced entry into the apartment, encountered assault rifle fire, suffered an immediate fatality with another team member wounded, in a situation where they could not see the shooter and had no idea as to the apartment floor plan. Under these circumstances the best course of action, is normally, for the team to conduct an "officer-down drill," make an immediate tactical withdrawal to a safe rally point, and reassess the new facts and circumstances. The BoI recognizes the stresses officers are under when being attacked and shot at. However, bravery and courage under fire cannot ever be an acceptable substitute for

sound procedures and officer safety. By not providing sufficient time for team preparation, Lieutenant #3 prematurely ordered the Entry Team to undertake a high-risk task from a position of extreme disadvantage. The hasty approval of this plan by the senior commanders compounded this error.

The BoI found that the Entry Team members exercised outstanding discipline in fire control when confronted by the screaming female running from the apartment. Under these circumstances, the OPD officers performed in the best traditions of tactical practices.

Timeline of Events



[2] Times are approximate unless otherwise noted. Time of events was based on OPD radio transmissions.

Summary of BoI Findings

The BoI reviewed volumes of pages from investigations, evidence, and documentation of the entire incident. The BoI reached a series of independent findings which are summarized below. Recommendations, training, and individual compliance are contained in the full report.

What Worked Well:

- The initial police response to the Officer Needs Help call was rapid and predictably chaotic but thorough and appropriate.
- Some members of the community responded to the emergency in a very helpful and concerned manner, providing comfort and calls to 9-1-1 for emergency help to treat the fatally wounded officers.
- Lieutenant #1 responded to the scene within minutes, assessed the situation, and attempted to impose some order on the evolving chaos. In the first few minutes, much had been accomplished by the responding officers and their sergeants. Injured officers were provided first aid, medical transportation was arranged, suspect descriptions and direction of flight broadcast, preliminary eye witnesses were identified and separated, and a containment perimeter had been initiated. Lieutenant #1 was newly promoted, had yet to attend command school, and had no recent operational experience in patrol, but did promptly telephone the immediate superior (who was off-duty) to notify him of the situation.
- The early development, by Lieutenant #1, of a credible eyewitness who saw the suspect being let into the apartment building at 2755-74th Avenue by another female was an important action.
- Lieutenant #2 did an excellent job in establishing the outer perimeter. This rapid perimeter probably helped contain the suspect and prevented his escape.
- The response and support of outside agencies was excellent and timely, providing aerial, canine, and personnel support.
- Actions by Lieutenant #4 while in contact with a CI provided additional information and gave further credibility to the eyewitness statement as to the suspect's location. This was an important action that provided corroboration to the eyewitness report.
- The plan to use tracking canines for suspect search operations, by Sergeant #2, was appropriate and well planned.
- After careful examination of each use of lethal force during the incident at 2755-74th Avenue, the BoI found that the Entry Team personnel acted within existing Oakland Police Department policy.

- The members of the Entry Team demonstrated high levels of courage and discipline during a chaotic scene where they were being shot at with an assault rifle. These officers held their fire when a female unexpectedly burst out of an interior room screaming and ran past the Entry Team. Under the circumstances this was an extraordinary accomplishment.

- The criminalist and evidence technicians accounted for each of the expended rounds and identified the locations where the officers or suspect were positioned at the time of discharge. The scientific reconstruction by the criminalist was outstanding and reflected a high standard of professional excellence.

What Needs to Be Improved:

- The vehicle stop: The officers' approach, together along the driver's side door was not in compliance with OPD training procedures or the best officer safety practices. Simply put, contact and cover protocols were not utilized.

- The command officers responding to the Officer-Needs-Help call failed to recognize the event as a complex incident, requiring the implementation of strategic command and control procedures. Almost all of the OPD senior command officers that responded went to the hospital first.

- Responding supervisors and command officers did not establish a central command post and failed to implement fundamental aspects of basic emergency incident management protocols. This led to a lack of development of an overall plan and little situational awareness.

- On-scene and responding personnel were not well controlled. The influx of people at the scene needed to be well coordinated to avoid placing them at risk and to ensure that they were properly utilized.

- There was no attempt to communicate with the area residents; there needed to be a coordinated communications plan to provide residents with situational alerts, alternative traffic routes, and perimeter requirements.

- Command officers and supervisors should have pocket-size field guides providing Incident Command System (ICS) steps, and training should be regularly updated and practiced to inculcate this idea into the OPD's operational culture.

- No command officer at the scene announced themselves as the Incident Commander (prior to the conclusion of the entry) as required by OPD Policy and Procedures. As a consequence, no one knew who was in-charge, adding to the growing confusion and disorganization. Lieutenant #3, was the most senior on-scene and self-asserted as the Incident Commander, but failed to carry out most of the basic requirements and thus contributed to the deterioration of critical incident management.

- The activities of the 115 OPD and outside agency units on-scene were disorganized and confused due to poor situational awareness and lack of clear

command and control. There was a failure to establish overall leadership as the incident evolved in complexity. Lieutenant #3's decision to decentralize into three separate tasks, is a sound tactic; however, it was flawed because there was no clear Incident Commander or coordination between the on-scene commanders. The lack of appropriate incident management contributed to the confused overall command and control. The absence of senior OPD leadership at a large-scale critical incident for 90 minutes was a serious deficiency.

- The information developed regarding the suspect's location was not transmitted, not received, or disregarded by persons who had placed themselves into decision-making roles.

- Lieutenant #3, who called for a SWAT Team callout over the police radio, failed to directly contact the Communications Division Supervisor, as required by OPD procedures. This action resulted in an unrecognized delay in activating the SWAT Team callout notification system by 45 minutes. This error delayed the SWAT Team elements (e.g., Hostage Negotiator Team, Tactical Operations Support Team, Sniper Team, and Entry Team) response.

- The location of interest – 2755-74th Avenue − was not formally scouted; no effort was made to ascertain the status of the apartment building residents; the apartment building interior configuration, as well as individual apartment floor plans, were unknown. Additionally, a record of previous incidents at the location was not requested. Last, all potential entry/exit or escape/evacuation points of the building were not properly considered.

- The officers and sergeants staffing the security perimeters, the designated arrest teams, and the ad hoc Entry Team were not provided with a suspect photograph and other identifying data when it was developed by CID specialists. Information related to the suspect's identity, criminal history, and the fact that he had an outstanding parole violation warrant was available well in advance of the order to enter and clear the suspect's apartment.

- The tactical decision maker was in "training status" as a Tactical Commander, and was expressly prohibited by the lead Tactical Commander from assuming tactical command. Nonetheless, Lieutenant #3 began to initiate a SWAT Team callout, ordered an ad hoc Entry Team to be formed, discounted the preponderance of evidence that the suspect was inside the apartment, and ordered the team to enter and clear without developing the requisite intelligence regarding the apartment floor plan, building layout, or occupancy of other residents. The serious decision-making discrepancies displayed by Lieutenant #3 raise questions as to the effectiveness of the OPD's selection process for the Tactical Commander position.

- The location of interest – the suspect's apartment – was not an "active shooter" or a barricaded suspect posing an immediate threat to hostages. The suspect was apparently contained within the apartment confines and not an at-large threat in the community. Absent exigent circumstances, there was no urgency to order an

expedited dynamic entry. The tactical decision maker had developed an unreasonably exaggerated sense of urgency, which was not justified by the circumstances.

- Every alternative to dynamic entry was disregarded (e.g., resident evacuations, establish telephone contact with suspect apartment occupants, bullhorn/PA announcements, location intelligence development, use of chemical agents, non-human assets and other accepted practices). The alternatives were dismissed with little or no discussion among the team members and command personnel.

- Best practices indicate that dynamic entry is only used as a last resort to protect lives from an immediate and imminent threat. The Department should carefully review the actions of all tactical entry situations to ensure that the practice of dynamic entry is only being used in appropriate circumstances. This was not the case in this specific instance.

- The decision to form an ad hoc Entry Team is a clear violation of OPD policy, and senior commanders did not intervene, but approved the action. The failure of senior command to stop the dynamic entry and to implement other tactical alternatives was of serious concern to this Board of Inquiry.

- The selection of all the on-scene SWAT Team leaders to form the ad hoc Entry Team was a fundamental command and control error. The decision to order the ad hoc Entry Team into the apartment caused a deficit in ground-level supervisory leadership – had there been a second, simultaneous tactical operation, the team would not have been able to effectively respond.

- The ad hoc Entry Team was composed of five SWAT Team leaders and three Team members, who were highly trained and well experienced in the best practices of tactical procedures. As such, they are not exempt from raising policy, safety, and procedural flaws to a superior officer.

- The personnel selected as ad hoc Entry Team members had not trained or practiced as a team. They were SWAT Team leaders and had not worked as an integrated unit to perform effectively under stressful operating conditions.

- Serious deficiencies in tactics and safety procedures were noted as soon as the ad hoc Entry Team crossed the apartment threshold and encountered unexpected high-powered assault rifle fire. The Entry Team was completely unprepared for this level of resistance and should have withdrawn to safety where careful assessment could be made regarding the new high-risk resistance presented and unanticipated developments.

- The Entry Team members did not have the Tactical Support Van with its full complement of safety and specialized equipment at the location of interest.

- The notification of next of kin was inappropriately conducted. In this incident, the wounded Sergeant #4 left the scene of an active homicide investigation, in soiled

and bloody uniform and was driven directly to the fallen officer's residence to help make the notification. Sergeant #4 had just been involved in a deadly use of force incident. As such, he should have remained at the scene and accessible to homicide investigators. Additionally, the BoI recommends that the OPD explore the feasibility of enhancing its notification process to allow for a designated set of personnel to respond, such as command staff level officers, chaplains, or support personnel to make the notification of next of kin.

BoI Findings and Recommendations Summary

BoI Finding	BoI Recommendation
The approach of Sergeant #1 and Officer #1 along the driver's door side of the suspect's vehicle was not in compliance with OPD training or best practices.	▪ Conduct field inspections to determine whether this method of vehicle approach is common place. ▪ Provide training to reduce the probability of such lapses in safety protocols during low-key traffic stops involving potential arrests. ▪ Consider this case study as a lesson learned on vehicle stop approach tactics. ▪ Encourage motorcycle officers to consider summoning a patrol vehicle to the scene of possible arrest situations. A patrol vehicle can offer additional tactical advantages that include cover and prevention of occupants fleeing on foot.
The initial response to the shooting of the officers was predictably chaotic but acceptable under the circumstances.	▪ Reinforce this positive performance (e.g., providing first aid, and establishing a containment perimeter) through training.
The ambulance response seemed slow.	▪ Review ambulance response times and assess the cause for the delay. Check to determine whether traffic congestion by police vehicles may have contributed, and emphasize "tactical parking" in roll call training.
Some members of the community responded in a very helpful and concerned manner, providing comfort and calls to 911 for emergency help to treat the fatally wounded officers.	▪ The Department should identify those community members who rendered aid and acknowledge them in a respectful and appropriate manner. ▪ This important lesson should be integrated into training and include citizen involvement to provide motivation for building strong ties and relationships to communities served by the police. This should be reinforced by supervisors.

BoI Finding	BoI Recommendation
	and command officers.
Transfer of cell phone Emergency 911 calls received by the regional California Highway Patrol (CHP) to the OPD was less than optimal.	▪ Conduct an audit to determine whether the system can be overwhelmed and at what threshold.
Issues related to implementing the Incident Command System (ICS) and filling critical positions led to a fundamental lack of planning.	▪ Provide training in the establishment of a command post, and emphasize the use of basic emergency incident management principles.
Responding commanders did not establish an appropriate command post.	▪ Ensure that training is provided to commanders and supervisors, emphasizing the importance of establishing a command post at the scene of all critical incidents.
Neither in the initial response nor in the subsequent hours did any commander announce themselves as the Incident Commander.	▪ OPD should develop a process for formal transfer of command and announcement at the scene of the incident.
Acting Lieutenant #2 did an excellent job in establishing the outer perimeter.	▪ OPD should review the perimeter training procedures to ensure that all commanders and supervisors are adequately prepared to establish an effective perimeter.
Information on the suspect was either not transmitted or not received by persons who had placed themselves into a decision-making capacity.	▪ This would have been resolved by the establishment of a command post with a central point for the receipt and coordination of critical information. OPD should ensure that communication and information sharing are emphasized in any emergency incident management training.
Lieutenant #3 called for a SWAT Team callout over the police radio, but did not directly contact the Communications Division Supervisor.	▪ Policies and training should be reviewed to ensure compliance with best practices in SWAT Team callout protocols. ▪ OPD should carefully review their SWAT Team callout processes and procedures to ensure that gaps in notification are identified and addressed. ▪ Training should be given to all supervisory and command officers concerning the appropriate procedures for a SWAT callout.
The location of 2755-74th Avenue was not formally scouted.	▪ OPD should review standard operating procedures related to tactical operations involving entry into a possible hostile situation.
The officers enforcing security perimeters, the specialized search teams, and the Entry Team were not given a photograph of the suspect when it was made available by Investigators. Without the photograph, many of these officers lacked a	▪ Procedures for sharing intelligence and suspect information to on-scene personnel should be reviewed. The integration of this information should be a part of OPD's training curricula as it

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common situational awareness and were not aware of how to identify the suspect beyond the verbal physical description.	relates to the ICS.
The use of tracking canines for suspect search operations was appropriate and well planned.	▪ OPD should identify training methods and opportunities that employ innovative search and suspect tracking techniques and capabilities.
Absent exigent circumstances, there was no urgency to order an expedited entry into the apartment. The BoI found that the order to force entry was not in compliance with OPD policies and best practices.	▪ OPD should consider re-training supervisors, command staff, and executive staff in sound tactical principles. Deficient practices should be identified and corrected to reflect policy requirements and best practices.
Statements provided by commanders involved in the decision to enter the suspect apartment showed a fundamental lack of understanding concerning basic principles surrounding fresh pursuit and lawful warrantless entries.	▪ OPD should provide search and seizure training to all commanders and ensure that ongoing training occurs at all ranks.
The SWAT Team leaders and members did not question the flawed plan and order issued by the Tactical Commander to enter and clear the suspect apartment. The professional responsibility to point out a flawed plan, prior to its execution, is incumbent upon every professional.	▪ Examine Departmental policies and preferences with regard to dynamic entry, unless there are compelling exigent circumstances. ▪ OPD Management needs to review and assess the content and operational concepts of the training provided to its SWAT Team. A full assessment should be made of military vs. police training for tactical planning, decision making, and operations. ▪ Initiate full audit and analysis procedures for every SWAT Team operation. The data needs to be analyzed for compliance and improvement in every case.
Serious deficiency in tactics and procedures were noted as soon as the Entry Team crossed the suspect apartment threshold and encountered unexpected high-powered assault rifle fire. The tactical decision to continue forward into the apartment was not sound and further endangered the Entry Team personnel.	▪ Re-evaluate the leadership requirements and selection procedures for SWAT Team leaders and tactical commanders. ▪ Develop field exercises to test the competency and decision-making capabilities of team leaders and tactical commanders to make tactically sound decisions under stress. ▪ Specific “Officer-Down Drills” should be practiced, including tactical withdrawal to a predetermined rally point. ▪ Policies and procedures need to be reviewed

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	for implementing strategic withdrawals to positions of safety when confronted with unexpected high-powered assault weapons.
Every alternative to a dynamic entry was ignored (e.g., evacuations, bullhorn/PA announcements, location information development, and use of chemical agents, developing an appropriate Tactical Command Post) and dismissed with little or no discussion among team members or command personnel. The decision to form an ad hoc Entry Team is a clear violation of OPD policy and every command officer present had a responsibility to terminate the improper action.	▪ Tactical commanders and incident commanders must be trained to avoid the temptation to force a dynamic entry when the available evidence clearly indicates that a deliberate approach is the most effective in saving lives and protecting the public and police. ▪ It is further recommended that tactical commanders become more involved in review, evaluation and approval of tactical plans prior to submission to the incident commander.
The ad hoc Entry Team consisted almost entirely of SWAT Team leaders (5) who are trained to be leaders rather than specific team members. They have not regularly trained in this configuration to perform under stressful operating conditions. While existing OPD policies related to the use of the SWAT Team are sound, these policies were disregarded in favor of the ad hoc Entry Team.	▪ Command staff should be trained and held accountable for the control of OPD resources to ensure that they are deployed only in accordance with established policies, absent urgent exigent circumstances.
After examining each use of lethal force during the incident at 2755-74th Avenue, the Board determined that Entry Team personnel acted within existing Oakland Police Department policy. They also exhibited extraordinary fire control when faced with an unarmed female fleeing from the apartment.	▪ The Entry Team should be commended for its extraordinary discipline in restraining the use of lethal force toward the unarmed female relative of the suspect as she fled the apartment.
The Entry Team members did not have the Tactical Support Van with its complement of safety and specialized equipment at the location of interest.	▪ OPD supervisors and commanders need to be trained, inspected, and held accountable for the appropriate performance of the OPD personnel. Safety equipment is costly and provided to protect the OPD's most valuable assets, its personnel.
Each of the expended rounds, together with ejected casings was accounted for, attributed to, and the location identified where the officer or suspect was positioned at the time of discharge. The crime scene and action inside the apartment was re-constructed by the criminalist, providing objective scientific evidence as to the precise position of the officers and suspect at each discharge and use of lethal force.	▪ Specific training is required, and should continue, in order to maintain fire control discipline. Carefully controlled and disciplined firing is required (short bursts of two-three rounds) and expected from SWAT Team members. The BoI recognized that under normal circumstances and in keeping with training, carefully controlled firing discipline is expected. However, the BoI also recognizes the extraordinary circumstances faced by Sergeant #4 who was aware that the suspect had killed two officers, was firing at the Entry Team, and

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	knew that Sergeant #2 had been shot. Sergeant #4 had just fallen in front of the suspect who was armed with a bayoneted assault rifle and was facing him.
The notification of next of kin was inappropriately executed. In this incident, the wounded Entry Team leader, Sergeant #4, left the scene in a soiled and bloody uniform and was driven, along with another Sergeant, directly to the fallen officer's residence. The BoI finds that it is not appropriate that an involved Entry Team member was allowed to leave the scene and that this speaks to improper command and control.	▪ The nature of the notification process is delicate and requires the most careful approach combined with clarity of thought to be of respectful help and support. It is poor procedure anytime for someone who has been involved in a traumatic and emotional incident to make the first notification, no matter how well intentioned. ▪ The policies should be reviewed to ensure that appropriate notifications are made that balance the wishes and preferences of the injured officer with the needs of the on-going investigation and acceptable professional decorum. Leaving an active crime scene, still in a uniform soiled with biological material and in need of personal medical attention is an understandable emotional desire but an inappropriate practice. Training should be developed with regard to this case example.

Conclusion

The BoI concluded that on March 21, 2009, the suspect was solely responsible for the murder of four veteran Oakland police officers, at two separate locations over a period of 2 hours. The suspect was a hardened career criminal with a history of predatory crimes. At the time of this incident, a felony warrant had been issued for his arrest for a parole violation. He clearly exhibited an utter disregard for human life. The BoI also noted that many members of the Oakland Police Department performed with high levels of courage and bravery during this trying ordeal. The BoI acknowledges the OPD's efforts and foresight to reach outside the Department for an independent inquiry into this incident. This action alone speaks volumes as to the Department's commitment to the integrity of the organization and transparency to the community, no matter how painful, by obtaining and addressing all the issues associated with this tragic event.